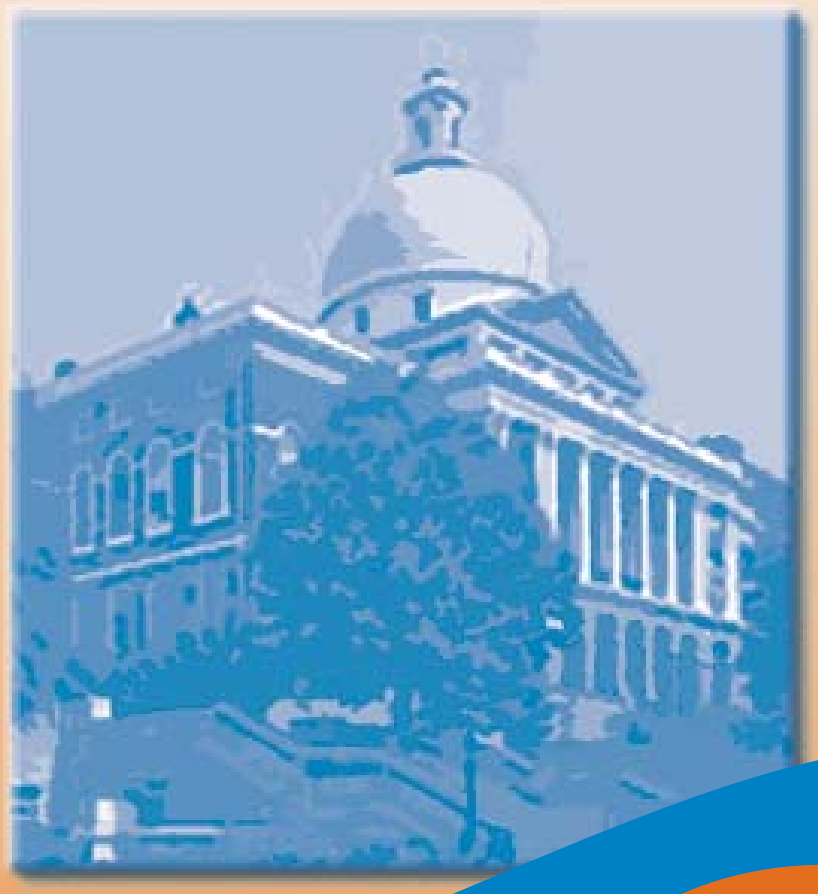
Commonwealth INDEMNITY PLAN

Medicare Extension Plan

Member Handbook for Medicare-Eligible Retirees



SERIES 2
EFFECTIVE JULY 1, 2003

Commonwealth Indemnity Plan
Administered by UNICARE

UniCare®

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Part 1: Medical Plan

Important Telephone Numbers (toll free)

Commonwealth Indemnity Plan	Express Scripts	United Behavioral Health
1-800-442-9300	1-877-828-9744	1-888-610-9039
TDD: 1-800-322-9161	TDD: 1-800-842-5754	TDD: 1-800-842-9489

Welcome to the Commonwealth Indemnity Medicare Extension Plan

Overview

This handbook is a guide to benefits for you and your Medicare-eligible dependents, covered under the Medicare Extension Plan. These benefits are provided through the Group Insurance Commission (GIC), the state agency responsible for the design and payment of all benefits for state employees, retirees and their dependents. This Plan is funded by the Commonwealth of Massachusetts and administered by UniCare.

UniCare provides administrative services for the Commonwealth Indemnity Plan such as claims processing, customer service, utilization management and medical case management at its Commonwealth Service Center in Andover, Massachusetts. UniCare is not the insurer of the Medicare Extension Plan.

Throughout this handbook, the Commonwealth Indemnity Medicare Extension Plan is referred to either by its full name, as the "Medicare Extension Plan" or as the "Plan." The Group Insurance Commission is referred to as the "GIC."

To fully understand your benefits, please read this handbook carefully.

How This Handbook Is Organized

Descriptions of the benefits available to you and your covered dependents are provided in the following three parts of this handbook.

Part 1: Medical Benefits

This part of the handbook describes the benefits available under the Medicare Extension Plan for medical services, treatment and supplies. These benefits are administered by **UniCare**. See page 2.

This handbook is not a description of your Medicare benefits. For more information about Medicare, read Your Medicare Handbook, produced by Medicare and available from your local Social Security office.

Part 2: Prescription Drug Plan

This part of the handbook describes the prescription drug plan which is administered by **Express Scripts**. See page 59.

Part 3: Mental Health, Substance Abuse and Enrollee Assistance Programs

This part of the handbook describes the Mental Health, Substance Abuse and Enrollee Assistance Programs for the Medicare Extension Plan, which are insured by **United Behavioral Health (UBH)**. See page 65.

If you have questions about any of your benefits, please refer to the contact information on page 5.

About Your Medical Plan

The Medicare Extension Plan supplements your Medicare coverage, thus providing you with comprehensive coverage for many health services including hospital stays, surgery, emergency care, preventive care, outpatient services and other medically necessary treatment. Services can be received from any provider you choose – anywhere in the world.

This handbook provides information on two different plan designs. The Medicare Extension Plan **without** CIC (Catastrophic Illness Coverage) provides benefits for many services at 80% coverage after Medicare considers your claims. The Medicare Extension Plan **with** CIC is a more comprehensive plan that increases the benefits for most services to 100% coverage after any applicable copays and deductibles have been paid.

How Medicare and the Commonwealth Indemnity Medicare Extension Plan Work Together

It is important to know that benefits are different depending on the service. Not every service is covered under the Medicare Extension Plan.

Medicare Part A provides benefits for hospital charges. Medicare Part B provides benefits for physician and other health care provider charges. The benefits provided by Medicare are based on established allowed charges for covered services. The Medicare Extension Plan will consider charges that are covered but not paid by Medicare, including the Part A inpatient hospital deductible and coinsurance and Part B deductible and coinsurance. The Medicare Extension Plan will also provide coverage for some services not covered by Medicare, such as preventive care and hearing aids.

The benefits for an enrollee or his/her dependent covered under the Medicare Extension Plan and enrolled in Medicare will be determined as follows:

(a) Expenses payable under the Medicare Extension Plan will be considered for payment only to the extent that they are covered under the Medicare Extension Plan and/or Medicare.

(b) In calculating benefits for expenses incurred, the total amount of those expenses will first be reduced by the amount of the actual Medicare benefits paid for those expenses, if any.

(c) Medicare Extension Plan benefits will then be applied to any remaining balance of those expenses.

Online Access to Plan and Medical Information on the Plan's Web Site

For your convenience, you can access a broad range of Plan-related and general health care information on the Commonwealth Indemnity Plan's web site at www.unicare-cip.com.

The **computer symbol**  that you see throughout this handbook indicates that information on the highlighted topic is available on the Plan's web site. For example, www.unicare-cip.com can help you by giving you the ability to:

- access data that gives you information you can use in making health care decisions
- find providers

- obtain information about your claims
- check out the Plan's discounts on products and services
- e-mail the Plan or order Plan supplies
- view the Plan's Member Handbook online

How to Receive the Highest Level of Benefits from Your Medical Plan

Please read the following information carefully to ensure that you receive the maximum level of Plan benefits for medically necessary services.

- The Commonwealth Service Center must be notified at 1-800-442-9300 for **all hospital admissions** and certain selected outpatient services. The **telephone symbol** ☎ you see throughout this handbook lets you know that, to obtain the maximum level of benefits, you or your provider must call the Commonwealth Service Center. Failure to do so will result in a reduction in benefits of up to $500. However, you do not need to call the Plan if you are outside the continental United States (the contiguous 48 states).

  Please refer to the Managed Care section of this handbook for specific notification requirements and responsibilities.

- Use the Plan's Preferred Vendors for the following services to enhance your level of benefits:

  – durable medical equipment
  – medical/diabetic supplies
  – home infusion therapy

  For a list of the Plan's current Preferred Vendors, log onto the Plan's web site at www.unicare-cip.com, or call the Commonwealth Service Center at 1-800-442-9300.

- Carry your Commonwealth Indemnity Medicare Extension Plan ID card with you at all times and always show it when you go for care. This enables your provider to confirm your eligibility for Plan benefits.

Important Plan Information

Overview

This section gives you important information about the Medicare Extension Plan, including:

- the Commonwealth Service Center and how its staff can help you
- the process for ordering new identification cards when needed
- steps to take to access a language interpreter when speaking with a customer service representative at the Commonwealth Service Center
- contact information when you have questions about your medical, prescription drug plan or mental health/substance abuse benefits
- the Plan's Member Confidentiality Statement

The Commonwealth Service Center

The Commonwealth Service Center is where UniCare administers services; processes claims; and provides customer service, utilization management and medical case management for the medical component of the Medicare Extension Plan. Representatives are available Monday through Friday from 8:30 a.m. to 5:00 p.m. to answer questions you and your family may have about your medical coverage. You can also access claims information 24 hours a day, seven days a week from our automated telephone line, or from the Plan's web site at www.unicare-cip.com.

When you call, you will speak with customer service representatives or patient advocates, depending on the nature of your call.

Customer service representatives are benefits specialists who can answer questions about:

- claim status
- notification requirements
- covered services
- Preferred Vendors
- Plan benefits

Patient advocates are registered nurses who can help you coordinate your health care needs with the benefits available under the Plan. The patient advocate will:

- provide information about the Managed Care Program, including Utilization Management, Medical Case Management, and Quality Centers for Transplant Services and other services
- answer questions about the Plan's coverage for hospital stays and certain outpatient services
- speak with you and your physician about covered and non-covered services to help you obtain care and coverage in the most appropriate health care setting, or
- assist you with optimizing benefits for covered services after you are discharged from the hospital

Your Identification Card

When you are enrolled in the Plan, you will receive a Commonwealth Indemnity Medicare Extension Plan identification (ID) card. When you need health care services, tell your physician, hospital or other provider that you are a member of Medicare **and** the Commonwealth Indemnity Medicare Extension Plan. Show your provider **both** your Medicare card and your Medicare Extension Plan ID card.

Important Plan Information

Your Medicare Extension Plan ID card contains useful information about your benefits and important telephone numbers you and your physician may need.

If you lose your ID card or need additional cards, you can order new cards from the Plan's web site at www.unicare-cip.com. You can also call the Commonwealth Service Center at 1-800-442-9300.

Interpreting and Translating Services

If you need a language interpreter when you contact the Commonwealth Service Center, a customer service representative will access a language line and connect you with an interpreter who will translate your conversation with the representative.

If you are deaf or hard of hearing and have a TDD machine, you can contact the Medicare Extension Plan by calling its telecommunications device for the deaf (TDD) line at 1-800-322-9161 or 1-978-474-5163.

Member Confidentiality Statement

This statement describes how UniCare protects the confidentiality of Medicare Extension Plan members' personal, financial and health information. It also explains your rights as well as UniCare's legal duties and privacy practices. UniCare's policies comply with the Health Insurance Portability and Accountability Act (HIPAA) that was signed into federal law in August 1996 to help improve the efficiency of the health care system in the United States.

The Plan's Member Confidentiality Statement is contained in Appendix A at the back of this handbook. Please read this statement carefully.

Important Contact Information

If you have questions, please refer to the contact information below:

For information about your medical benefits:

Commonwealth Indemnity
Medicare Extension Plan
P.O. Box 9016
Andover, MA 01810-0916
1-800-442-9300
TDD: 1-800-322-9161
www.unicare-cip.com

For information about your prescription drug plan:

Express Scripts
1-877-828-9744 (toll free)
TDD: 1-800-842-5754
www.express-scripts.com

For information about your mental health and substance abuse benefits:

United Behavioral Health
1-888-610-9039 (toll free)
TDD: 1-800-842-9489
www.liveandworkwell.com
(access code 10910)

Your Costs

Overview

This section describes the costs that you may be responsible for paying in connection with services covered by the Plan. These costs include deductibles, copayments and coinsurance. This section also explains how the Plan reimburses health care providers.

Deductibles

A deductible is a fixed dollar amount you pay for certain services before the Plan begins paying benefits for you or a covered dependent. The Plan's deductible is applied to any balances remaining after Medicare considers your claim. The deductible amounts you must satisfy are shown in the chart below.

Deductibles	Coverage Without CIC (Non-Comprehensive Coverage)	Coverage With CIC (Comprehensive Coverage)
Individual Calendar Year Deductible	$100	$35
Inpatient Hospital Quarterly Deductible	$100	$50

Individual Calendar Year Deductible

The individual calendar year deductible is the amount each person must pay before benefits for many services begin for that calendar year. The individual calendar year deductible is applied to any balances that remain after Medicare considers your claims.

For example: If you have coverage with CIC and you go to a provider for a medical problem in January, you will have to pay $35 of the allowed amount remaining after Medicare's payment. Once you have paid the $35 calendar year deductible, you will not have to pay it again for the remainder of the year, regardless of the types of services you receive.

The Plan determines to which providers you owe any deductible amounts based on the order in which the claims are received. You will receive an Explanation of Benefits (EOB) that will indicate which provider(s) may be owed the deductible.

Some of the types of charges to which the calendar year deductible applies are office visits, physical therapy and outpatient hospital services. The calendar year deductible does not apply to preventive care visits, laboratory tests and x-rays. For more information, check the Benefit Highlights section for a complete listing of where the calendar year deductible is applied.

Deductible Carryover

Any amounts you pay toward the individual calendar year deductible in the last three months of a calendar year will be applied toward the deductible for the next calendar year. Carryover does not apply to the inpatient hospital quarterly deductible.

Inpatient Hospital Quarterly Deductible

The inpatient hospital quarterly deductible is a per-person, per-calendar year quarter deductible. Each time you or a covered dependent is admitted to a hospital, you are responsible for this deductible. However, once a covered person satisfies this deductible in any calendar year quarter, he or she will not have to satisfy the deductible again during that same calendar year quarter. The deductible is applied to any balances that remain after Medicare considers your claims. The inpatient hospital quarterly deductible does not apply toward the individual calendar year deductible.

For example: If you have coverage with CIC and you are admitted to a hospital in January and stay overnight, you will be responsible to pay the $50 deductible on the balance that remains after Medicare's payment. If you were re-admitted in March, you will not have to pay another deductible, as March is in the same calendar year quarter as January. However, if you were re-admitted in May, you may incur another $50 deductible.

Copayments

A copayment ("copay") is a fixed dollar amount you pay to a provider at the time of service. Copay amounts vary depending on the type of service you receive. They are always deducted before the individual deductible is applied. Copays do not count toward satisfying deductibles, coinsurance amounts or out-of-pocket maximums.

For example: As a member of the Medicare Extension Plan, you owe a $5 copay when you have a preventive care (routine) office visit. You do not owe a copay if you go to a physician's office for a reason other than a preventive care visit.

You are also responsible for a $25 copay every time you go to the emergency room. This copay is waived if you are admitted to the hospital.

Coinsurance

Coinsurance is the percentage of the allowed amount that you must pay for covered services after the deductible is satisfied. For example, if the Plan pays 80% of the allowed amount for certain services, you are responsible for paying the remaining 20%. In addition, you may be responsible for the difference between the allowed amount and the provider's charge for services received from providers outside of Massachusetts. Coinsurance is applied to any balances that remain after Medicare considers your claims. To see which benefits coinsurance applies to, refer to the Benefit Highlights section.

Out-of-pocket Maximum

To protect you from large medical expenses, the Medicare Extension Plan with CIC limits the amount of coinsurance you pay out-of-pocket each year for some covered services. This out-of-pocket maximum is $500. There is no out-of-pocket maximum without CIC coverage for the Medicare Extension Plan.

Once you reach the out-of-pocket limit, the Plan pays 100% of the allowed amount for the designated covered services for the rest of the calendar year.

Your Costs

Deductibles, copayments and certain coinsurance amounts do not apply toward your out-of-pocket maximum. Any amounts paid in excess of the allowed amount, or for non-covered services, also do not apply toward your out-of-pocket maximum.

To find out which coinsurance amounts apply toward the out-of-pocket maximum, see the Benefit Highlights section.

Allowed Amount

The Allowed Amount is either the amount Medicare allows for covered services or the Reasonable and Customary Charge – whichever is lower.

Under Massachusetts General Law, Chapter 32A: Section 20, providers who render services in Massachusetts are prohibited from billing you for amounts in excess of the Medicare Extension Plan determined or Allowed Amounts.

Reasonable and Customary Charge

Charges for covered services are reasonable and customary to the extent they do not exceed the general level of charges for like or similar treatment, services or supplies by other providers in the area where the charges are incurred. Charges in excess of the reasonable and customary allowance are not considered for payment under the Medicare Extension Plan.

Allowed Charge

Allowed Charge means the lower of actual charges or a schedule of charges for like or similar treatment, services or supplies. The allowed charge applies to those benefits for which Preferred Vendors have been designated.

If you use a Preferred Vendor, you will maximize your benefits because you will not be balance billed.

In Massachusetts, if you choose to use a provider other than a Preferred Vendor, you are responsible for the coinsurance amounts up to the Allowed Charge. Providers of services in Massachusetts are prohibited by law from billing you for amounts in excess of Plan determined or Allowed Amounts.

Outside Massachusetts, if you choose to use a provider other than a Preferred Vendor, you are responsible for amounts in excess of the Allowed Amount. Amounts in excess of the Allowed Amount are not applied toward satisfying the deductible, coinsurance or out-of-pocket maximum.

Provider Reimbursement

The Medicare Extension Plan reimburses providers on a fee-for-service basis. The Plan does not withhold portions of benefit payments from providers, nor offer incentive payments to providers related to controlling the utilization of services. Explanations of provider payments are detailed in your Explanations of Benefits (EOBs). Under the Plan, providers are not prohibited from discussing the nature of their compensation with you.

How to Submit a Claim

Before the Medicare Extension Plan can process your claims, your claims must first be submitted to Medicare for consideration. Most hospitals, physicians or other health care providers will submit claims to Medicare for you. You will receive an Explanation of Medicare Benefits (EOMB) that explains what Medicare paid and if there are balances remaining.

Once Medicare processes your claims, the balance is automatically sent to the Commonwealth Service Center where benefits under the Medicare Extension Plan are determined. This process is called **Medicare Crossover**. You are not responsible for paying any balances until the Medicare Crossover process is completed. At that time you will receive an EOB from the Medicare Extension Plan.

If the situation arises where you need to submit your own claim, you must first submit the claim to Medicare. You must then submit written proof of the claim to the Commonwealth Service Center that includes:

- Medicare EOMB
- diagnosis
- date of service
- amount of charge
- name, address and type of provider
- name of enrollee
- enrollee's ID number
- name of patient
- description of each service or purchase
- other insurance information, if applicable
- accident information, if applicable
- proof of payment, if applicable

If the proof of payment you receive from a provider contains information in a foreign language, please provide the Plan with a translation of this information, if possible.

The Medicare Extension Plan claim form may be used to submit written proof of a claim. Original bills or paid receipts from providers will also be accepted as long as the information described above is included.

For your convenience, a claim form can be found at the back of this book.  You can also request this form from www.unicare-cip.com.

Filing Deadline

Written proof of a claim must be submitted to the Plan within two years from the date of service. Claims submitted after two years will be accepted for review if it is shown that the person submitting the claim was mentally or physically incapable of providing such proof of submission in the required time frame.

Claims Review Process

The Medicare Extension Plan routinely reviews submitted claims to evaluate the accuracy of billing information about services performed. The Plan may request written documentation such as operative notes, procedure notes, office notes, pathology reports and x-ray reports from your provider. In cases of suspected claim abuse or fraud, the Plan may require that the person whose disease, injury or pregnancy is the basis of the claim be examined by a physician chosen by the Plan. This examination must be approved by the Executive Director of the GIC and will be performed at no expense to the enrollee and/or covered dependent.

Restrictions on Legal Action

No legal action or suit to recover benefits for charges incurred while covered under the Medicare Extension Plan may be started before 60 days after written proof of a claim has been furnished. Further, no such action or suit may be brought more than three years

Your Claims

after the time such proof has been furnished. If either time limit is less than permitted by state law where you reside when the alleged loss occurred, the limit is extended to be consistent with that state law.

Right of Reimbursement

The Plan will have a lien on any recovery made by you or your dependent for an injury or disease to the extent you or your dependent has received benefits for such injury or disease from the Plan. That lien applies to any recovery made by you or your dependent from any person or organization that was responsible for causing such injury or disease, or from their insurers. Neither you nor your dependent will be required to reimburse the Plan for more than the amount you or your dependent recover for such injury or disease.

You or your dependent must execute and deliver such documents as may be required, and do whatever is necessary to help the Plan in its attempts to recover benefits it paid on behalf of you or your dependent.

Claims Inquiry

If you have questions about your claims, you can contact the Commonwealth Service Center in one of the following ways to request a review of your claim:

- Call the Plan at 1-800-442-9300.
-  E-mail the Plan from www.unicare-cip.com.
- Write to the Medicare Extension Plan, Claims Department, P.O. Box 9016, Andover, MA 01810-0916.

If you have additional information, please include it with your letter. You will be notified of the result of the investigation and of the final determination.

24-Hour Access to Claims Information

You can also check the status of your claims 24 hours a day, seven days a week in the following two ways:

1. Call the Plan at 1-800-442-9300 and select the option to access our automated information line.
2.  Log onto www.unicare-cip.com. A personal identification number protects the privacy of your information.

Appeal Rights

You have the right to appeal a benefit determination made by the Medicare Extension Plan within 60 days of the notification of the determination. Your appeal should state why you believe the final determination was in conflict with the Plan provisions. You should also include all supporting documentation (at your own expense) that you or your health care provider believes supports your position.

The Plan will conduct a review of the submitted documentation, and a decision will be made within 30 days after receipt of your written request. The results of the appeal review will be sent to you in writing. The letter will contain the specific reasons for the Plan's decision and, if applicable, instructions as to any additional appeal procedures that may be available.

Appeals relating to the Managed Care Review Program (inpatient hospital admissions, durable medical equipment, home infusion therapy and home health care) should be directed to:

Commonwealth Indemnity
Medicare Extension Plan
Appeals Review
P.O. Box 2011
Andover, MA 01810-0035

All other appeals should be directed to:

Commonwealth Indemnity
Medicare Extension Plan
Appeals Review
P.O. Box 2075
Andover, MA 01810-0037

Request and Release of Medical Information

The Plan's policies for releasing and requesting medical information comply with the Health Insurance Portability and Accountability Act (HIPAA). For more details, refer to the Member Confidentiality Statement located in Appendix A at the back of this handbook.

Managed Care Program

Overview

The Managed Care Program under the Medicare Extension Plan includes the following three components:

1. Utilization Management
2. Medical Case Management
3. Quality Centers for Transplant Services and Specialized Procedures

The Managed Care Program determines the medical necessity and appropriateness of certain health care services by reviewing clinical information. This process, called Utilization Management, a standard component of most health care plans, ensures that benefits are paid appropriately for services that meet the Plan's definition of medical necessity. Managed Care Program staff will inform you in advance regarding what services will be covered. The Managed Care Program reviews the benefits available to you from Medicare and helps coordinate coverage. This Program helps control costs while preserving the ability of the Group Insurance Commission to offer the benefits of an indemnity plan to enrollees.

Managed Care Program staff includes patient advocates who are registered nurses and other nurse reviewers working with physician advisors. To determine medical necessity, nurses speak with your physicians, hospital staff, and/or other health care providers to evaluate your clinical situation and the circumstances of your health care. A physician advisor on behalf of the Managed Care Program may speak with your physician to discuss the proposed treatment and/or the setting in which it will be provided.

The review process is initiated when you or someone on your behalf notifies the Commonwealth Service Center that:

- you or your dependent will be or has been admitted to the hospital, or
- a provider has recommended one of the services noted on the Notification Requirements chart on the following page.

You will also find the Medicare Extension Plan's Notification Requirements on the Plan's web site at www.unicare-cip.com.

Important: **If your provider or you fail to notify the Commonwealth Service Center within the required time frame as specified in the Notification Requirements chart on page 13, your benefits may be reduced by as much as $500. The purpose of notifying the Plan is to give the Plan sufficient time to determine if the proposed service will be covered. This process minimizes your risk of incurring charges.**

☎ Managed Care Notification Requirements*

Treatment / Service	Notification Requirement
An Overnight Hospital Stay: Non-emergency Admission	At least 7 calendar days before the admission
Emergency Admission	Within 24 hours (next business day)
Organ Transplants: Liver, Lung, Kidney, Heart, Bone Marrow, Kidney / Pancreas, All Other	At least 21 calendar days before transplant-related services begin
Durable Medical Equipment: (if the purchase price exceeds $500 or the expected rental charges will exceed $500 over the period of use)	At least one business day before ordering the equipment
Home Health Care Provided By: • Home Health Agencies • Visiting Nurse Associations • Private Duty Nurses	At least one business day before the services begin if Medicare is not going to cover the services
• Home Infusion Therapy Companies	At least one business day before the services begin

☎ To obtain the maximum level of benefits, you or your provider must notify the Commonwealth Service Center at 1-800-442-9300.

* Claims submission does not constitute notification.

Managed Care Program

Utilization Management Program

Inpatient Hospitalizations

Initial Review: The Medicare Extension Plan must review and determine the medical necessity of all inpatient hospital admissions. You or someone on your behalf must initiate this process by calling the Commonwealth Service Center at least seven (7) days in advance of a non-emergency admission, and within 24 hours or the next business day of an emergency admission.

The purpose of this process is to inform you prior to a non-emergency admission, or as soon as possible after an emergency admission, whether the admission will be considered for benefits under the Plan. In doing so, you minimize your risk of incurring non-covered services.

Medicare covers 60 days at 100% after Medicare's deductible for medically necessary care that occurs within a "benefit period." Those 60 days can occur as a result of one or multiple hospitalizations. A benefit period begins the day you are first admitted to a hospital and ends when you have been out of a hospital or skilled nursing facility for 60 straight days. The benefit period also ends if you are in a skilled nursing facility but have not received skilled care in that facility for 60 straight days. After that 60 day period, the next time you are admitted to a hospital, a new benefit period begins and your hospital and skilled nursing Medicare benefits are renewed. There is no limit on the number of Medicare benefit periods that you can have. If you have additional questions about your Medicare benefits, please consult **Your Medicare Handbook** or call your local Social Security office.

Depending on the benefits available to you from Medicare, the patient advocate will determine the need for a review of the medical necessity and appropriateness of the hospitalization. If a review is needed, a patient advocate will discuss with your physician the medical necessity and appropriateness of the planned or ongoing treatment and of the setting to determine the benefits available under the Commonwealth Indemnity Medicare Extension Plan.

If the patient advocate is unable to confirm the medical necessity and appropriateness of the treatment, the inpatient hospital setting or the anticipated length of stay, a physician advisor will speak with your physician before the Plan makes a final decision. If the admission is determined to be not medically necessary and appropriate, the patient advocate will promptly notify you, your physician and the hospital.

Continued Stay Review: You should notify the Medicare Extension Plan if your stay in any hospital adds up to or is near 60 days within one benefit period. When this occurs, the patient advocate will begin a review of the continuing hospital stay. The patient advocate will call your physician while you are in the hospital to confirm the medical necessity and appropriateness of the hospital stay.

If the patient advocate is unable to confirm that the continued hospitalization is medically necessary, a physician advisor will speak with your physician before making the final decision. If the continued stay is determined to be not medically necessary and appropriate, the patient advocate will promptly notify you, your physician and the hospital.

During continued stay review, the patient advocate will also work with the hospital staff to facilitate early planning for care that may be required after your discharge.

Durable Medical Equipment Over $500

Any durable medical equipment (DME) ordered by a physician that is expected to cost more than $500 is subject to Plan review. The $500 may be the result of either the purchase price or the total rental charges.

The Plan must be notified at least one (1) business day before the equipment is ordered from the equipment provider. Upon notification, a patient advocate will contact your health care provider to obtain clinical information that will be used to determine the medical appropriateness of the equipment. A patient advocate will notify you regarding whether the Plan will authorize coverage for the equipment.

If you obtain equipment through a Preferred Vendor, the item will be covered at 100% of the Allowed Amount after the calendar year deductible. Please note that if a covered item is not available through a Preferred Vendor and you obtain it from another provider, it will only be covered at 80% of the Allowed Amount after the calendar year deductible.

Home Health Care

When a physician prescribes home infusion or other home health care services, the Plan must be notified at least one business day before services begin, if it has been determined that Medicare will not cover the full amount of the services requested. Upon notification, a patient advocate will call your health care provider to obtain clinical information that will be used to determine the medical appropriateness of the home health care services. A patient advocate will notify you whether the Plan will authorize coverage for the services.

Appeals Process

If an initial denial occurs before or while health care services are being provided, and the attending physician or patient believes that the determination warrants an immediate reconsideration, either party may request reconsideration of that determination over the telephone on an expedited basis.

For an immediate reconsideration, the Commonwealth Service Center must receive requests and all supporting information within three (3) business days of the initial notification of denial. The reconsideration will be completed within two (2) business days of receipt of all necessary supporting documentation. The decision is then communicated in writing to the patient and the patient's health care provider.

If the denial is upheld, the patient can take the next step and appeal the decision to:

Commonwealth Indemnity
Medicare Extension Plan
Appeals Review
P.O. Box 2011
Andover, MA 01810-0035

Medical Case Management

The Medical Case Management Program facilitates the timely provision of appropriate, cost-effective, quality health care services that are tailored to meet an individual's health care needs. A medical case manager is a registered nurse with expertise to assist you and your family when you are faced with a serious medical problem such as stroke, cancer, spinal cord injury or other conditions that require multiple medical services. The medical case manager will:

- help you and your family cope with the stress associated with an illness or injury by facilitating discussions about health care planning, and enhancing the coordination of services among multiple providers
- work with the attending physician and other involved health care providers to evaluate the present and future health care needs of the patient

- provide valuable information regarding available resources for the patient
- work with the mental health/substance abuse benefits administrator when you or your dependent's condition requires both medical and mental health services, to coordinate services and maximize your benefits under the Plan
- explore alternative funding sources or other resources in cases where medical necessity exists but there is a limit to coverage under the Plan
- facilitate the management of chronic disease states by promoting education, wellness programs, self help and prevention
- promote the development of an appropriate plan of care to ease the transition from a stay in a facility to the return home

Quality Centers and Designated Hospitals for Transplants

The Plan has designated certain hospitals as Quality Centers for organ transplants. These hospitals were chosen for their specialized programs, experience, reputation and ability to provide high quality care. The purpose of this program is to facilitate the provision of timely, cost-effective, quality services to eligible Plan enrollees and their dependents at specialized facilities. A medical case manager is available to support the patient and family before the transplant procedure and throughout the recovery period. The medical case manager will:

- assess the patient's ongoing needs
- coordinate services while the patient is awaiting a transplant
- help the patient and family to optimize Plan benefits
- maintain communication with the transplant team
- facilitate transportation and housing arrangements, if needed
- facilitate discharge planning alternatives
- coordinate home care plans as necessary
- explore alternative funding sources or other resources in cases where there is need but there are limited benefits under the Plan

Although you and your covered dependents have the freedom to choose any health care provider for these procedures, you can maximize your benefits when you use one of these Quality Centers. You or someone on your behalf should notify the Plan as soon as your physician recommends a transplant evaluation.

Coronary Artery Disease Secondary Prevention Program

The Coronary Artery Disease Secondary Prevention Program is designed to help you make the necessary lifestyle changes that can reduce your cardiac risk factors. It is available to members with a history of heart disease. The program is available through the Medical Case Management Program. You can call a medical case manager to ask about your eligibility and available programs.

Other Health Management Resources

MedCall®

The Plan's MedCall program provides a 24-hour toll-free number to access nurse counselors who can answer your questions about procedures or symptoms that you would like to discuss. Nurse counselors can provide information about appropriate care settings and help you prepare for a doctor's visit. They can also discuss your medications and any potential side effects. MedCall also serves as a referral source for local, state and national self-help agencies. To speak with a nurse counselor, call the MedCall toll-free number, 1-800-424-8814. You will need to provide the following Plan-specific code: 1002.

By calling the above number, you can also access MedCall's library of more than 200 audio tapes to get automated information over the phone on many health related topics. To view the list of available audio tapes, log onto www.unicare-cip.com.

Healthwise Knowledgebase

This is a comprehensive online database of unbiased, up-to-date medical information. You can use this database to research medications, medical conditions, medical tests, treatment options and other medical topics. To access Healthwise, log onto www.unicare-cip.com.

Making Healthy Decisions

Making Healthy Decisions is a powerful research tool available on the Plan's web site, www.unicare-cip.com, that gives you easy access to comprehensive and reliable health care information to help you evaluate your health care options. Making Healthy Decisions provides you with the following:

- information about health conditions or surgical procedures
- questions to ask at doctors' visits
- help with selecting hospitals

You can also use this web site tool to find out what types of treatment and surgical options are available for specific conditions, along with non-surgical alternatives such as drug therapies or lifestyle changes. In addition, you can research which hospitals are most experienced in performing the procedure you need, along with each hospital's complication rate for that procedure.

To access Making Healthy Decisions, you will need to enter the following password when prompted: u2decide.

Benefit Highlights

A Summary of Your Medical Benefits

This section contains a summary of your medical benefits under the Medicare Extension Plan after consideration by Medicare, as follows:

- the level of benefits coverage – with CIC (comprehensive coverage) and without CIC (non-comprehensive coverage)
- any coinsurance, copays or deductibles you are responsible for paying in connection with a service or supply
- any limits on the maximum number of visits allowed per calendar year
- any maximum dollar amounts per calendar year that are associated with a service or supply

Important: **The information contained in this section is only a summary of your medical benefits. For complete details of your medical plan benefits coverage, please refer to the Description of Covered Services section of this handbook, which follows the Benefit Highlights section.**

The **book symbol** 🕮 next to each service listed in Benefit Highlights gives the corresponding page in the Description of Covered Services section or other sections where the benefit is more fully described.

The **telephone symbol** ☎ you see throughout this handbook lets you know that, to obtain the maximum level of benefits, you or your provider must call the Commonwealth Service Center at 1-800-442-9300. Failure to do so will result in a reduction in benefits up to $500. However, you do not need to call the Plan if you are outside the continental United States (the contiguous 48 states).

The **computer symbol** 💻 that you see throughout this handbook indicates that information on the highlighted topic is available on the Plan's web site, www.unicare-cip.com.

Summary of Covered Services (after consideration by Medicare)

	Without CIC	With CIC
☎ Inpatient Hospital Services in an Acute Medical, Surgical or Rehabilitation Facility		📖 Also see page 28
Semi-Private Room, ICU, CCU and Ancillary Services	100% after the inpatient hospital quarterly deductible	100% after the inpatient hospital quarterly deductible
Medically Necessary Private Room	100% of the semi-private room rate after the inpatient hospital quarterly deductible	100% of the semi-private room rate after the inpatient hospital quarterly deductible
Inpatient Diagnostic Laboratory and Radiology Expenses	100%	100%
☎ Transplant Services		📖 Also see page 35
Quality Centers and Designated Hospitals for Selected Transplant Services	100% after the inpatient hospital quarterly deductible	100% after the inpatient hospital quarterly deductible
Other Hospitals	80% after the inpatient hospital quarterly deductible	80% after the inpatient hospital quarterly deductible. The 20% coinsurance amount does not count toward the out-of-pocket maximum.

☎ To obtain the maximum level of benefits, you or your provider must notify the Commonwealth Service Center at 1-800-442-9300. See the Managed Care section for specific notification requirements and responsibilities.

Benefit Highlights

Summary of Covered Services (after consideration by Medicare)

	Without CIC	With CIC
Other Inpatient Facilities 📖 Also see page 28		
• Sub-acute Care Hospital/Facility • Transitional Care Hospital/Facility • Long-term Care Hospital/Facility • Chronic Disease Hospital/Facility • Skilled Nursing Facility	**For Days Paid by Medicare:** Part A deductible and coinsurance up to 100 days after the calendar year deductible; then 80% for the remainder of the calendar year up to a calendar year maximum benefit of $7,500 **For Days *Not* Paid by Medicare:** 80% up to the calendar year maximum benefit of $7,500	**For Days Paid by Medicare:** Part A deductible and coinsurance up to 100 days after the calendar year deductible; then 80% for the remainder of the calendar year up to a calendar year maximum benefit of $10,000 **For Days *Not* Paid by Medicare:** 80% up to the calendar year maximum benefit of $10,000 Whether or not Medicare pays, the 20% coinsurance amount does not count toward the out-of-pocket maximum.
Emergency Treatment for an Accident / Sudden Serious Illness 📖 Also see page 29		
Emergency Room Charge	100% after a $25 copay per visit; copay waived if admitted	100% after a $25 copay per visit; copay waived if admitted
Radiology	100%	100%
Diagnostic Laboratory	100%	100%

Summary of Covered Services (after consideration by Medicare)

	Without CIC	With CIC
Non-Emergency Treatment		Also see page 29
Emergency Room Charge	100% after a $25 copay per visit and after the calendar year deductible	100% after a $25 copay per visit and after the calendar year deductible
Radiology	80%	100%
Diagnostic Laboratory	80%	100%
Surgery		Also see page 29
Inpatient or Outpatient	**In Massachusetts:** 100% of Part B deductible and coinsurance amount **Outside Massachusetts – Medicare Assigned:** 100% of Part B deductible and coinsurance amount **Outside Massachusetts – Medicare Unassigned:** 100% of Part B deductible and coinsurance amount	**In Massachusetts:** 100% of Part B deductible and coinsurance amount **Outside Massachusetts – Medicare Assigned:** 100% of Part B deductible and coinsurance amount **Outside Massachusetts – Medicare Unassigned:** 100% of Part B deductible and coinsurance amount; then 80% of the difference between the Medicare payment and the covered charge

To obtain the maximum level of benefits, you or your provider must notify the Commonwealth Service Center at 1-800-442-9300. See the Managed Care section for specific notification requirements and responsibilities.

Benefit Highlights

Summary of Covered Services (after consideration by Medicare)

	Without CIC	With CIC
Outpatient Medical Care		Also see pages 29-35
For Services at a Hospital (other than the services listed below)	100% after the calendar year deductible	100% after the calendar year deductible
Diagnostic Laboratory Testing and Radiology Expenses	80%	100%
Physical Therapy and Occupational Therapy	80% after the calendar year deductible	**If Medicare Pays:** 100% of the Part B deductible and coinsurance amount **If Medicare Does Not Pay:** 80% after the calendar year deductible
Speech Therapy (as described in the Description of Covered Services)	80% after the calendar year deductible up to a maximum benefit of $2,000 per calendar year	100% after the calendar year deductible up to a maximum benefit of $2,000 per calendar year
Chemotherapy	80% after the calendar year deductible	100% after the calendar year deductible

Summary of Covered Services (after consideration by Medicare)

	Without CIC	With CIC
Physician Services		Also see page 33
Non-Emergency Treatment at Home, Office or Outpatient Hospital	100% after the calendar year deductible	100% after the calendar year deductible
Hospital Inpatient	100%	100%
Emergency Treatment	100%	100%
Chiropractic Care or Treatment	80% after the calendar year deductible; maximum benefit of $40 per visit, 20 visits per calendar year	80% after the calendar year deductible; maximum benefit of $40 per visit, 20 visits per calendar year
Private Duty Nursing		Also see page 34
Inpatient (must not duplicate services that a hospital or facility is licensed to provide)	100% up to a calendar year maximum benefit of $1,000 after the calendar year deductible. The maximum benefit includes benefits paid by Medicare, then 80%.	100% up to a calendar year maximum benefit of $1,000 after the calendar year deductible. The maximum benefit includes benefits paid by Medicare, then 80%.
Outpatient	80% up to a calendar year maximum benefit of $4,000 after the calendar year deductible. The maximum benefit includes benefits paid by Medicare.	80% up to a calendar year maximum benefit of $8,000 after the calendar year deductible. The maximum benefit includes benefits paid by Medicare. The 20% coinsurance amount does not count toward the out-of-pocket maximum.

To obtain the maximum level of benefits, you or your provider must notify the Commonwealth Service Center at 1-800-442-9300. See the Managed Care section for specific notification requirements and responsibilities.

Benefit Highlights

Summary of Covered Services (after consideration by Medicare)

	Without CIC	With CIC
☎ Home Health Care		📖 Also see page 32
Medicare Certified Home Health Agencies and Visiting Nurse Associations	80% after the calendar year deductible	80% after the calendar year deductible
☎ Home Infusion Therapy		📖 Also see page 45
Preferred Vendor[1]	100% after the calendar year deductible	100% after the calendar year deductible
Other Vendors	80% after the calendar year deductible .	80% after the calendar year deductible. The 20% coinsurance amount does not count toward the out-of-pocket maximum.
Preventive Care		📖 Also see pages 33-34
Office Visits (refer to frequency limits on pages 33-34)	100% after a $5 copay per visit. The copay does not count toward the calendar year deductible.	100% after a $5 copay per visit. The copay does not count toward the calendar year deductible or the out-of-pocket maximum.
Annual Gynecological Visits	100% after a $5 copay per visit	100% after a $5 copay per visit
Immunizations	100%	100%

[1] Please call the Commonwealth Service Center for the names of the Preferred Vendor or contracted providers. You can also find this information on our web site at www.unicare-cip.com.

☎ To obtain the maximum level of benefits, you or your provider must notify the Commonwealth Service Center at 1-800-442-9300. See the Managed Care section for specific notification requirements and responsibilities.

Summary of Covered Services (after consideration by Medicare)

	Without CIC	With CIC
Hospice		Also see page 35
Medicare Certified Hospice	100% after the calendar year deductible	100% after the calendar year deductible
Bereavement Counseling	80% up to a maximum of $1,500 per family after the calendar year deductible	80% up to a maximum of $1,500 per family after the calendar year deductible. The 20% coinsurance amount does not count toward the out-of-pocket maximum.
Early Intervention Services for Children		Also see page 31
Programs Approved by the Department of Public Health	80% up to a calendar year maximum benefit of $3,200 and a lifetime maximum benefit of $9,600	80% up to a calendar year maximum benefit of $3,200 and a lifetime maximum benefit of $9,600. The 20% coinsurance amount does not count toward the out-of-pocket maximum.
Ambulance		Also see page 29
	100% of the first $25	100% after the calendar year deductible
Coronary Artery Disease (CAD) Secondary Prevention Program		Also see page 16
Designated Programs Available Through Medical Case Management	90%	90%. The 10% coinsurance does not count toward the out-of-pocket maximum.

Benefit Highlights

Summary of Covered Services (after consideration by Medicare)

	Without CIC	With CIC
☎ Durable Medical Equipment (DME)		📖 Also see pages 36-37
Preferred Vendor[1]	100% after the calendar year deductible	100% after the calendar year deductible
Other Vendors	80% after the calendar year deductible	80% after the calendar year deductible. The 20% coinsurance amount does not count toward the out-of-pocket maximum.
Hospital-Based Personal Emergency Response System (PERS)		📖 Also see page 36
Installation	80% up to a maximum benefit of $50 after the calendar year deductible	80% up to a maximum benefit of $50 after the calendar year deductible. The 20% coinsurance amount does not count toward the out-of-pocket maximum.
Rental Fee	$40 per month maximum benefit	$40 per month maximum benefit
Prostheses[2]		📖 Also see page 34
	If Medicare Pays: 100% of the Medicare deductible and Medicare coinsurance **If Medicare Does Not Pay:** 80%	**If Medicare Pays:** 100% of the Medicare deductible and Medicare coinsurance **If Medicare Does Not Pay:** 80%

[1] Please call the Commonwealth Service Center at 1-800-442-9300 for the names of the Preferred Vendors. You can also find this information on the Plan's web site at www.unicare-cip.com. If an item is not available through a Preferred Vendor and you obtain it from another provider, it will be covered at 80%.

[2] Breast prostheses are covered at 100% after the calendar year deductible.

☎ To obtain the maximum level of benefits, you or your provider must notify the Commonwealth Service Center at 1-800-442-9300. See the Managed Care section for specific notification requirements and responsibilities.

Summary of Covered Services (after consideration by Medicare)

	Without CIC	With CIC
Braces[1] 📖 Also see page 30		
	If Medicare Pays: 100% of the Medicare deductible and Medicare coinsurance **If Medicare Does Not Pay:** 80%	**If Medicare Pays:** 100% of the Medicare deductible and Medicare coinsurance **If Medicare Does Not Pay:** 80%
Hearing Aids 📖 Also see page 31		
	100% of the first $500 after the calendar year deductible; then 80% of the next $1,500, up to a maximum benefit of $1,700 every two years	100% of the first $500 after the calendar year deductible; then 80% of the next $1,500, up to a maximum benefit of $1,700 every two years. The 20% coinsurance amount does not apply to the out-of-pocket maximum.
Eyeglasses / Contact Lenses 📖 Also see page 42		
	80%. Limited to the initial set within six months following cataract surgery.	100%. Limited to the initial set within six months following cataract surgery.
Family Planning Services 📖 Also see page 31		
Office Visits and Procedures	100% after the $5 copay per visit and after the calendar year deductible	100% after the $5 copay per visit and after the calendar year deductible
All Other Covered Medical Services 📖 Also see pages 29-35		
	80% after the calendar year deductible	80% after the calendar year deductible

[1] Orthopedic shoe(s) with attached brace is covered at 100% after the calendar year deductible.

Prescription Drug Plan – Benefits Administered by Express Scripts
📖 See page 59. For more information, call 1-877-828-9744 (toll free).

Mental Health, Substance Abuse and Enrollee Assistance Programs – Benefits Insured by United Behavioral Health. 📖 See page 65. For more information, call 1-888-610-9039 (toll free).

Description of Covered Services

The following pages contain descriptions of various covered services under the Medicare Extension Plan. Please refer to the Benefit Highlights section for information regarding benefit percentages, copays, coinsurance amounts, deductibles, out-of-pocket maximum amounts and durations of benefits that apply to these covered services. The Benefit Highlights section also shows you the difference in the level of coverage for Medicare Extension Plan coverage with CIC and without CIC.

☎ Inpatient Hospital Services

Charges for the following services qualify as covered hospital charges if the services are for a hospital stay.

1. Room and board provided to the patient
2. Anesthesia, radiology and pathology services
3. Hospital pre-admission testing if you or your covered dependent is scheduled to enter the same hospital where the tests are performed within seven (7) days after they are performed. If the hospital stay is cancelled or postponed after the tests are performed, the charges will still be covered as long as the physician presents a satisfactory medical explanation.
4. Medically necessary services and supplies charged by the hospital, except for special nursing or physician's services
5. Physical, occupational and speech therapy
6. Diagnostic and therapeutic services

Services at Other Inpatient Facilities

Other inpatient facilities include:

- Sub-acute Care Hospital/Facility
- Transitional Care Hospital/Facility
- Long-term Care Hospital/Facility
- Chronic Disease Hospital/Facility
- Skilled Nursing Facility

Covered charges for these facilities include the following services:

1. Room and board
2. Routine nursing care, but not including the services of a private-duty nurse or other private-duty attendant
3. Physical, occupational and speech therapy provided by the facility or by others under arrangements with the facility
4. Such drugs, biologicals, medical supplies, appliances and equipment as are ordinarily provided by the facility for the care and treatment of its patients
5. Medical social services
6. Diagnostic and therapeutic services furnished to patients of the facility by a hospital or any other health care provider
7. Other medically necessary services as are generally provided by such treatment facilities

Coverage in "Other Inpatient Facilities"

NOTE: To qualify for coverage in "Other Inpatient Facilities," the purpose of the care in these facilities must be the reasonable improvement in the patient's condition. A physician must certify that the patient needs and receives, at a minimum, skilled nursing or skilled rehabilitation services on a daily or intermittent basis. Continuing care for a patient who has not demonstrated reasonable clinical improvement is not covered.

☎ To obtain the maximum level of benefits, you or your provider must notify the Commonwealth Service Center at 1-800-442-9300. See the Managed Care section for specific notification requirements and responsibilities.

Emergency Treatment for an Accident or Sudden/Serious Illness

An emergency is an illness or medical condition, whether physical or mental, that manifests itself by symptoms of sufficient severity, including severe pain that in the absence of immediate medical attention could reasonably be expected by a prudent lay person, who possesses an average knowledge of health and medicine, to result in serious jeopardy to physical and/or mental health, serious impairment to bodily functions, serious dysfunction of any bodily organ or part, or, in the case of pregnancy, a threat to the safety of a member or her unborn child.

Massachusetts provides a 911 emergency response system throughout the state. If you are faced with an emergency, call 911. In other states, check with your local telephone company about emergency access numbers. Keep emergency numbers and the telephone numbers of your physicians in an easily accessible location.

Surgical Services

The payment to a surgical provider for operative services includes the usual pre-operative, intra-operative and post-operative care.

Charges for the following services qualify as covered surgical charges:

1. Medically necessary surgical procedures when performed on an inpatient or outpatient basis (hospital, physician's office or surgical center)
2. Services of an assistant surgeon when:
   (a) medically necessary
   (b) the assistant surgeon is trained in a surgical specialty related to the procedure and is not a fellow, resident or intern in training, and
   (c) the assistant surgeon serves as the first assistant surgeon. (Second or third assistants are not covered.)
3. Reconstructive and restorative surgery, but limited to the following:
   (a) Reconstruction of defects resulting from surgical removal of an organ or body part for the treatment of cancer. Such restoration must be within five (5) years of the removal surgery.
   (b) Correction of a congenital birth defect that causes functional impairment for a minor dependent child
   (c) Breast reconstruction following a mastectomy
   (d) Reconstruction of the other breast to produce a symmetrical appearance after mastectomy
   (e) Coverage for prostheses and treatment of physical complications of all stages of mastectomy, including lymphedemas

Medical Services

Charges for the following services qualify as covered medical charges, but only if they do not qualify as covered hospital or surgical charges:

1. **Ambulance/Air Ambulance** – only in the event of an emergency and when medically necessary. Benefits are payable only for transportation to the nearest facility equipped to treat the condition. Transportation to or from medical appointments, including dialysis, is not a covered service.
2. **Anesthesia** and its administration
3. **Audiology Services** – expenses for the diagnosis of speech, hearing and language disorders are covered when provided by a

licensed audiologist when the services are provided in a hospital, clinic or private office. Services provided in a school-based setting are not covered. The Plan does not cover services that a school system is obligated to provide under Chapter 766 in Massachusetts or under a similar law in other states.

4. **Braces** – replacement of such equipment is also covered when required due to pathological change or normal growth.

   Orthotics are covered when they meet the following criteria:

   (a) ordered by a physician

   (b) custom fabricated (molded and fitted) to the patient's body

   (c) for use by that patient only

   Also see Exclusions.

5. **Cardiac Rehabilitation Treatment** – provided by a cardiac rehabilitation program (see definition on page 43).

6. **Certified Nurse Midwife Services** – provided in the home or in a hospital.

7. **Circumcision** – when provided for newborns up to 30 days from birth.

8. **Crutches** – replacement of such equipment is covered when required due to pathological change or normal growth.

9. **Diabetes** – benefits will be paid for charges incurred by a covered person for medically necessary equipment, supplies and medications for the treatment of diabetes. Coverage will include outpatient self-management training and patient management, as well as nutritional therapy.

   Coverage will apply to services and supplies prescribed by a doctor for insulin dependent, insulin using, gestational and non-insulin using diabetes. The Plan will provide benefits for these services and supplies when prescribed by a physician under the medical component of the Plan or under the prescription drug plan as indicated below.

   Diabetic drugs, insulin and the following diabetic supplies are covered under the prescription drug plan:

   (a) blood glucose monitors

   (b) test strips for glucose monitors

   (c) insulin

   (d) syringes and all injection aids

   (e) lancets and lancet devices

   (f) prescribed oral agents

   (g) glucose agents and glucagon kits

   (h) urine test strips

   The following diabetic supplies are covered under the medical component of the Plan:

   (a) blood glucose monitors, including voice synthesizers for blood glucose monitors for use by legally blind persons

   (b) test strips for glucose monitors

   (c) laboratory tests, including glycosylated hemoglobin (HbA1c) tests, urinary protein/microalbumin and lipid profiles

   (d) insulin pumps and all related supplies

   (e) insulin infusion devices

   (f) syringes and all injection aids

   (g) lancets and lancet devices

   (h) urine test strips

(i) insulin measurement and administration

(j) aids for the visually impaired

(k) podiatric appliances for the prevention of complications associated with diabetes

Diabetes Self-management Training
Diabetes self-management training and patient management, including medical nutritional therapy, may be conducted individually or in a group, but must be provided by:

- an education program recognized by the American Diabetes Association, or
- a health care professional who is a diabetes educator certified by the National Certification Board for Diabetes Educators

Coverage will include all educational materials for such program. Benefits will be provided as follows:

(a) upon the initial diagnosis of diabetes

(b) when a significant change occurs in symptoms or conditions, requiring changes in self-management

(c) when refresher patient management is necessary, or

(d) when new medications or treatments are prescribed

As used in this provision, "patient management" means educational and training services furnished to a covered person with diabetes in an outpatient setting by a person or entity with experience in the treatment of diabetes. This will be in consultation with the doctor who is managing the patient's condition. The physician must certify that the services are part of a comprehensive plan of care related to the patient's condition. In addition, the services must be needed to ensure therapy or compliance or to provide the patient with the necessary skills and knowledge involved in the successful management of the patient's condition.

10. **Early Intervention Services for Children** – coverage of medically necessary Early Intervention Services for children from birth until their third birthdays includes occupational therapy, physical therapy, speech therapy, nursing care, psychological counseling, and services provided by early intervention specialists or by licensed or certified health care providers working with an Early Intervention Services program approved by the Department of Public Health.

11. **Family Planning Services** – office visits and procedures for the purpose of contraception. Office visits include evaluations, consultations and follow-up care. Procedures include fitting for a diaphragm or cervical cap; the insertion, re-insertion, or removal of an IUD or Levonorgestrel (Norplant); and the injection of progesterone (Depo-Provera). FDA approved contraceptive drugs and devices are available through the prescription drug plan.

12. **Gynecological Visits** – annual gynecological examination, including Pap smear

13. **Hearing Aids** – when prescribed by a physician; replacement only when necessary due to pathological change or loss of the hearing aid

14. **Hearing Screenings** for newborns

Description of Covered Services

15. ☎ **Home Health Care** – and skilled nursing services provided under a plan of care prescribed by a physician and delivered by a Medicare-certified Home Health Care agency (refer to definition of Home Health Care in Plan Definitions on page 45).

    The following services are only covered if the covered individual is receiving approved part-time, intermittent skilled care furnished or supervised by a registered nurse or licensed physical therapist:

    (a) Part-time, intermittent home health aide services consisting of personal care of the patient and assistance with activities of daily living

    (b) Physical, occupational, speech and respiratory therapy by the appropriate licensed or certified therapist

    (c) Nutritional consultation by a registered dietitian

    (d) Medical social services provided by a licensed medical social worker

    However, the following charges do not qualify as covered home health care charges:

    (a) Charges for custodial care or homemaking services

    (b) Services provided by you, a member of your family or any person who resides in your home. Your family consists of you, your spouse and your children, as well as brothers, sisters and parents of both you and your spouse.

16. **Infertility Treatment** – non-experimental infertility procedures including, but not limited to:

    (a) Artificial Insemination (AI) also known as Inter-uterine Insemination (IUI)

    (b) In Vitro Fertilization and Embryo Placement (IVF-EP)

    (c) Gamete Intrafallopian Transfer (GIFT)

    (d) Zygote Intrafallopian Transfer (ZIFT)

    (e) Natural Ovulation Intravaginal Fertilization (NORIF)

    (f) Cryopreservation of eggs as a component of covered infertility treatment (costs associated with banking and/or storing inseminated eggs is reimbursable only upon the use of such eggs for covered fertility treatment)

    (g) Sperm, egg and/or inseminated egg procurement and processing, and banking of sperm or inseminated eggs, to the extent such costs are not covered by the donor's insurer, if any

    (h) Donor sperm or egg procurement and processing, to the extent such costs are not covered by the donor's insurer, if any

    (i) Intracytoplasmic Sperm Injection (ICSI) for the treatment of male factor infertility

    In Vitro Fertilization and other associated infertility procedures, with the exception of artificial insemination, are limited to five (5) attempts (refer to definition of "Attempt" on page 43).

☎ To obtain the maximum level of benefits, you or your provider must notify the Commonwealth Service Center at 1-800-442-9300. See the Managed Care section for specific notification requirements and responsibilities.

Charges for the following services are not considered covered services:

(a) experimental infertility procedures

(b) surrogacy

(c) reversal of voluntary sterilization

(d) procedures for infertility not meeting the Plan's definition on page 46.

Facility fees will be considered as covered services by the Plan only from a licensed hospital or a licensed free-standing ambulatory surgical center.

17. **Laboratory Tests** – must be ordered by a physician

18. **Manipulative Therapy** – chiropractic or osteopathic manipulation used to treat neuromuscular and/or musculoskeletal conditions on a short-term basis when the potential for functional gains exists. These services are subject to review by the Plan to determine medical necessity.

19. **Occupational Therapy** – by a registered occupational therapist when ordered by a physician

20. **Orthotics** – covered when they meet the following criteria:

(a) ordered by a physician

(b) custom fabricated (molded and fitted) to the patient's body

(c) for use by that patient only

Also see Exclusions.

21. ☎ **Oxygen** and its administration

22. **Physical Therapy** – physical therapy used to treat neuromuscular and/or musculoskeletal conditions on a short-term basis when the potential for functional gains exists. The Plan only covers one-on-one therapies rendered by a registered physical therapist or certified physical therapy assistant (under the direction of a physical therapist) and when ordered by a physician. These services are subject to review by the Plan to determine medical necessity.

23. **Physician Services** – medically necessary services provided by a licensed physician acting within the scope of that license providing such services in the home, hospital, physician's office, or other medical facility. Charges by physicians for their availability in case their services may be needed are not covered services. The Plan only pays physicians for the actual delivery of medically necessary services. Telephone and e-mail consultations are not covered.

24. **Preventive Care Schedule:**

(a) **For children (up to age 19)** – The Plan covers preventive level office visits or physical examinations for children as follows:

- two examinations, including hearing screening, while the newborn is in the hospital;
- every two months until 18 months of age; then
- every three months from 18 months of age until 3 years of age; then
- every 12 months from 3 years of age until 19 years of age.

(b) **For adults (age 19 and over)** – The Plan covers preventive or routine level office visits or physical examinations as follows:

- every 36 months (three years) until age 40; then

☎ To obtain the maximum level of benefits, you or your provider must notify the Commonwealth Service Center at 1-800-442-9300. See the Managed Care section for specific notification requirements and responsibilities.

- every 24 months (two years) between ages 40 and 59; then
- every 12 months (once a year) after age 60.

(c) The following screening procedures and laboratory tests performed as a component of preventive care:

- hemoglobin
- urinalysis
- glaucoma testing
- flexible sigmoidoscopy (exam of the lower bowel)
- chemistry profile for the purpose of preventive screening includes the following:
  - complete blood count (CBC)
  - glucose
  - blood urea nitrogen (BUN)
  - creatinine
  - transferase alanine amino (SGPT)
  - transferase asparate amino (SGOT)
  - thyroid stimulating hormone (TSH)

(d) The following screening procedures and laboratory tests performed as indicated:

- blood cholesterol level (every five years)
- mammograms (once between the ages of 35 and 40: yearly after age 40)
- stool for occult blood (annually after age 50)

(e) Gynecological examination annually (every 12 months) for women, including Pap smear

(f) Immunizations

25. ☎ **Private Duty Nursing Care** – highly skilled nursing care needed continuously during a block of time (greater than two hours) provided by a registered nurse while you are confined to your home. If you have the Medicare Extension Plan with CIC, charges for a Licensed Practical Nurse (LPN) are provided as shown in the Benefit Highlights section. Private Duty Nursing Care must:

    (a) be medically necessary

    (b) provide skilled nursing services

    (c) be exclusive of all other home health care services, and

    (d) not duplicate services that a hospital or facility is licensed to provide

26. **Prostheses** – replacement of such equipment is also covered when required due to pathological change or normal growth.

27. **Radioactive Isotope Therapy**

28. **Radiotherapy**

29. **Routine Foot Care** – charges for medically necessary routine foot care are covered if accompanied by medical evidence documenting:

    - in the case of an ambulatory patient, an underlying condition causing vascular compromise, such as diabetes, or
    - in the case of a non-ambulatory patient, a condition that is likely to result in significant medical complications in the absence of such treatment.

30. **Speech-language Pathology Services** – Expenses for the diagnosis and treatment of speech, hearing and language disorders are covered when provided by a licensed

☎ To obtain the maximum level of benefits, you or your provider must notify the Commonwealth Service Center at 1-800-442-9300. See the Managed Care section for specific notification requirements and responsibilities.

speech-language pathologist or audiologist when the services are provided in a hospital, clinic or private office. Services provided in a school-based setting are not covered.

Covered speech-language pathology services include the following:

- the examination and remedial services for speech defects caused by physical disorders
- physiotherapy in speech rehabilitation following laryngectomy

The Plan does not cover the following:

- services that a school system is obligated to provide under Chapter 766 in Massachusetts or under a similar law in other states
- language therapy for learning disabilities such as dyslexia
- cognitive therapy or rehabilitation
- voice therapy

31. **X-Rays** and other radiological exams

☎ Transplant Services

Benefits are payable, subject to benefit maximums, deductibles and limitations, for necessary medical and surgical expenses incurred for the transplanting of a human organ. (To receive the maximum benefit, please refer to Quality Centers and Designated Hospitals for Transplant Services on page 16.)

Human Organ Donor Services

Benefits are payable, subject to benefit maximums, deductibles and limitations, for necessary expenses incurred for delivery of a human organ (any part of the human body, excluding blood and blood plasma) and medical expenses incurred by a person in direct connection with the donation of a human organ.

Benefits are payable for any person who donates a human organ to a person covered under the Plan, whether or not the donor is a member of the Plan.

The Plan also covers expenses for human leukocyte antigen testing or histocompatibility locus antigen testing necessary to establish the suitability of a bone marrow transplant donor. Such expenses consist of testing for A, B or DR antigens, or any combination thereof, consistent with the guidelines, criteria, rules and regulations established by the Massachusetts Department of Public Health.

Hospice Care Services

Upon certification by a physician that the covered individual is terminally ill, benefits are payable for charges incurred for the covered hospice care services when the patient is enrolled in a Medicare-certified hospice program. The services must be furnished under a written plan of hospice care, established by a hospice and periodically reviewed by the medical director and interdisciplinary team of the hospice.

A person is considered to be terminally ill when given a medical prognosis of six (6) months or less to live.

List of Covered Hospice Care Services

The Plan covers the following hospice care services:

1. part-time, intermittent nursing care provided by or supervised by a registered nurse
2. physical, respiratory, occupational and speech therapy by an appropriate licensed or certified therapist
3. medical social services
4. part-time, intermittent services of a home health aide under the direction of a registered nurse

☎ To obtain the maximum level of benefits, you or your provider must notify the Commonwealth Service Center at 1-800-442-9300. See the Managed Care section for specific notification requirements and responsibilities.

5. necessary medical supplies and medical appliances
6. drugs and medications prescribed by a physician and charged by the hospice
7. laboratory services
8. physicians' services
9. transportation needed to safely transport the terminally ill person to the place where that person is to receive a covered hospice care service
10. psychological, social and spiritual counseling for the patient furnished by a:

    (a) physician
    (b) psychologist
    (c) member of the clergy
    (d) registered nurse, or
    (e) social worker

11. dietary counseling furnished by a registered dietitian
12. respite care
13. bereavement counseling furnished to surviving members of a terminally ill person's immediate family or other persons specifically named by a terminally ill person. Bereavement counseling must be furnished within 12 months after the date of death and it must be furnished by a:

    (a) physician
    (b) psychologist
    (c) member of the clergy
    (d) registered nurse, or
    (e) social worker

    No hospice benefits are payable for services not included in the List of Covered Hospice Care Services, nor for any service furnished by a volunteer, or for which no charge is customarily made.

Hospital-Based Personal Emergency Response Systems (PERS)

Benefits are payable for the rental of a PERS if:

1. the service is provided by a hospital
2. the patient is homebound and at risk medically, and
3. the patient is alone at least four (4) hours a day, five (5) days a week, and is functionally impaired

No benefits are payable for the purchase of a PERS unit.

☎ Durable Medical Equipment (DME)

To meet the Plan's definition of DME, the service or supply must be:

1. provided by a DME supplier
2. designed primarily for therapeutic purposes or to improve physical function
3. provided in connection with the treatment of disease, injury or pregnancy upon the recommendation and approval of a physician
4. able to withstand repeated use, and
5. ordered by a physician

Benefits are payable if the DME service or supply meets the Plan's definition of DME and is determined to be medically necessary.

The Plan covers the rental of DME up to the purchase price. If the Plan determines that the purchase cost is less than the total expected rental charges, it may decide to purchase such equipment for your use. If you choose to continue to rent the equipment, the Plan will not cover rental charges that exceed the purchase price.

☎ To obtain the maximum level of benefits, you or your provider must notify the Commonwealth Service Center at 1-800-442-9300. See the Managed Care section for specific notification requirements and responsibilities.

Excluded Items

No benefits are available for items such as, but not limited to, air conditioners, air purifiers, arch supports, bed pans, blood pressure monitors, commodes, corrective shoes, dehumidifiers, dentures, elevators, exercise equipment, heating pads, hot water bottles, humidifiers, shower chairs, whirlpools or spas. These items do not qualify as covered durable medical equipment.

Important: Using Preferred Vendors will maximize your benefit by reducing your out-of-pocket cost. Call 1-800-442-9300 for a list of Preferred Vendors or find this information on www.unicare-cip.com. 

Exclusions

The Medicare Extension Plan does not provide benefits for the following services. Please note that charges that are excluded by the Plan do not count toward out-of-pocket maximums and deductible amounts.

1. A service or supply furnished without the recommendation and approval of a physician (that is, without an order).

2. A service or supply reviewed under the Managed Care Program and determined by the Plan not to be medically necessary.

3. A service or supply that is determined by the Plan to be experimental or investigational; that is, inadequate or lacking in evidence as to its effectiveness, through the use of objective methods and study over a long enough period of time to be able to assess outcomes. The fact that a physician ordered it or that this treatment has been tried after others have failed does not make it medically necessary.

4. A service or supply that is not medically necessary for the care and treatment of an injury, disease or pregnancy, unless:

   (a) furnished by a hospital for routine care of a child during a hospital stay that begins with birth and while the child's mother is confined in the same hospital; or

   (b) furnished by a hospital or physician for covered preventive care, as described under Description of Covered Services on pages 33-34; or

   (c) such service or supply qualifies as a covered Hospice Care service (refer to pages 35-36)

5. A service or supply furnished for an occupational injury or disease for which a person is entitled to benefits under a Workers' Compensation Law or similar law.

6. A service or supply provided by you, a member of your family or by any person who resides in your home. Your family consists of you, your spouse and children, as well as brothers, sisters and parents of both you and your spouse.

7. Acupuncture and acupuncture related services

8. Arch supports

9. The amount by which a charge for blood is reduced by blood donations

10. Acne-related services, such as the removal of acne cysts, injections to raise acne scars, cosmetic surgery, dermabrasion or other procedures to plane the skin. Benefits are provided for outpatient medical care to diagnose or treat the underlying condition identified as causing the acne.

11. Blood pressure cuff (sphygmomanometer)

12. Breast pumps

13. Chair cars/vans

14. Cognitive rehabilitation or therapy

15. Computer-assisted communication devices

16. Custodial care

17. Services related to surgery undertaken as the result of denture wear or to prepare for the fitting of new dentures

18. Dietary or nutritional counseling or services provided by a dietitian or nutritional counselor, except as otherwise noted on pages 31 and 36

19. Drugs not used in accordance with indications approved by the Food and Drug Administration (off label use of a prescription drug), unless the use meets the definition of medically necessary as determined by the Plan or the drug is specifically designated as covered by the Plan

20. Over-the-counter drugs

21. Any services or supplies furnished by, or covered as a benefit under, a program of any government or its subdivisions or agencies except for the following:
    (a) a program established for its civilian employees
    (b) Medicare (Title XVIII of the Social Security Act)
    (c) Medicaid (any state medical assistance program under Title XIX of the Social Security Act)
    (d) a program of hospice care

22. Hearing aid batteries or ear molds

23. Hippotherapy

24. Experimental treatment for infertility

25. Incontinence supplies

26. Internet providers or e-mail consultations

27. Language therapy for learning disabilities such as dyslexia

28. Lift or riser chairs

29. Long-term maintenance care or long-term therapy

30. Certain manipulative therapy services, such as paraffin treatment; microwave, infrared and ultraviolet therapies; diathermy; massage therapy; acupuncture; aerobic exercise; rolfing therapy; Shiatsu; sports conditioning/weight training; or therapies performed in a group setting

31. Massage therapy or services provided by a massage therapist or neuromuscular therapist

32. A medical service or supply for which a charge would not have been made in the absence of medical insurance

33. Any medical services, including in vitro fertilization, in connection with the use of a gestational carrier or surrogate

34. Orthopedic/corrective shoe(s), except when the shoe(s) attaches directly to a brace

35. Orthopedic mattresses

36. Oxygen equipment required for use on an airplane, or other means of travel

37. Personal comfort items that could be purchased without a prescription, such as air conditioners, air purifiers, bed pans, blood pressure monitors, commodes, dehumidifiers, dentures, elevators, exercise equipment, heating pads, hot water bottles, humidifiers, telephones, shower chairs, televisions, whirlpools or spas and other similar items

Exclusions

38. Redundant or duplicate services.
    A service is considered redundant when the same service(s) and supplies are being provided, or being used concurrently, to treat the condition for which it is ordered.

39. Reversal of voluntary sterilization

40. Sensory integration therapy

41. Any services and treatments required under law to be provided by the school system for a child

42. Sexual reassignment surgery and related services

43. Smoking cessation programs or medications

44. Stairway lifts and stair ramps

45. Storage of autologous blood donations or other bodily fluids or specimens, except when done in conjunction with use in a scheduled procedure that is covered under the Plan

46. Surface electromyography (SEMG)

47. Telephone consultations

48. Vision care, including:

    (a) eye examinations, surgery, services or supplies furnished in conjunction with the determination or correction of refractive errors such as astigmatism, myopia, hyperopia and presbyopia

    (b) the portion of an eye examination to determine if you need prescription lenses and the specifications for those lenses

    (c) orthoptics or visual therapy for correction of vision

    (d) radial keratotomy and related laser surgeries

49. Voice therapy

Limitations

The Medicare Extension Plan limits benefits for the following services and products:

1. **Ambulance** used for transportation services other than in the case of an emergency. Please see the definition of "Emergency Treatment" on page 45. Benefits are payable only for transportation to the nearest facility equipped to treat the condition. Transportation required for medical appointments, including dialysis treatment, is not covered.

2. **Air and sea ambulance services** are limited to the medically necessary transfer to the nearest facility equipped to treat the condition.

3. **Assistant surgeon services** are limited to the services of only one assistant surgeon per procedure when medically necessary. Second and third assistants are not covered.

   Non-physician assistants at surgery, such as physicians assistants (PAs), nurses and technicians are not covered. Interns, residents and fellows are also not covered. Chiropractors, dentists, optometrists and certified midwives are not covered as surgical assistants or as assistant surgeons.

4. **Bone density testing** is not covered when done solely for the purpose of screening or prevention.

5. **Cosmetic procedures/services** are not covered, with the exception of the initial surgical procedure to correct appearance that has been damaged by an accidental injury that occurred on or after the member's effective date of continuous health care coverage under any plan provided by the GIC. Only the first such surgery is covered.

6. **Dental benefits** are limited. The Medicare Extension Plan is a medical plan, not a dental plan. The Plan provides benefits for covered services relating to dental care or surgery in the following situations only:

   (a) Emergency treatment rendered by a dentist within 72 hours of an accidental injury to the mouth and natural sound teeth. This treatment is limited to the initial first aid (trauma care), reduction of swelling, pain relief, covered non-dental surgery and non-dental diagnostic x-rays.

   (b) Oral surgical procedures for non-dental medical treatment, such as the reduction of a dislocated or fractured jaw or facial bone, and removal or excision of benign or malignant tumors, are provided to the same extent as other covered surgical procedures described on page 48.

   (c) The following procedures when a member has a serious medical condition* that makes it essential that he or she be admitted to a hospital as an inpatient, or to a surgical day care unit or ambulatory surgical facility as an outpatient, in order for the dental care to be performed safely:

      (1) extraction of seven (7) or more teeth

      (2) gingivectomies (including osseous surgery) of two (2) or more gum quadrants

*** Serious medical conditions include, but are not limited to, hemophilia and heart disease.**

Limitations

(3) excision of radicular cysts involving the roots of three (3) or more teeth

(4) removal of one (1) or more impacted teeth

Facility, anesthesia and related charges are only covered when the dental treatment or services are covered under the Plan.

7. **Electrocardiograms (EKGs)** are not covered when done solely for the purpose of screening or prevention.

8. **Eyeglasses/contact lenses** are limited to the provision, replacement or fitting for the initial set only when subsequent to an injury to the eye or up to six (6) months following cataract surgery.

9. **In Vitro Fertilization** and other associated infertility procedures, with the exception of artificial insemination, are limited to five (5) attempts (refer to definition of "Attempt" on page 43).

10. **Orthotics** are limited to medically necessary devices. Charges for test or temporary orthotics are not covered. Charges for video tape gait analysis and diagnostic scanning are not covered. Arch supports are also not covered.

11. **Routine screening** is not covered other than the Preventive Care Services specified in the Description of Covered Charges on pages 33-34.

12. **Treatment of Temporomandibular Joint (TMJ) disorder** is limited to the initial diagnostic examination and testing and medically necessary surgery.

13. **Weight loss programs** are limited to the treatment of morbid obesity (at least 100% overweight) while under the care of a physician. Any such program is subject to periodic review for medical necessity and progress.

14. **Wigs** are limited to the replacement of hair loss as a result of treatment of any form of cancer or leukemia. The maximum benefit for a wig is limited to $350 per calendar year.

Plan Definitions

Some terms used in the Medicare Extension Plan handbook are defined below as they relate to your benefits. Read these definitions carefully; they will help you understand what is covered under the Plan.

"Acute Care" – a level of care required as a result of the sudden onset or worsening of a condition that necessitates short term, intensive medical treatment. Acute inpatient care must be provided at a facility licensed as an acute care hospital. See definition for "Hospital."

"Allowed Amount" – either the amount Medicare allows for covered services or the reasonable and customary charge – whichever is lower.

"Allowed Charge" – means the lower of actual charges or a schedule for like or similar treatment, services or supplies. The schedule is based on the Preferred Vendor's rates.

"Ancillary Services" – the services and supplies that a facility ordinarily renders to its patients for diagnosis or treatment during the time the patient is in the facility. Ancillary services include such things as:

1. use of special rooms, such as operating or treatment rooms
2. tests and exams
3. use of special equipment in the facility
4. drugs, medications, solutions, biological preparations and medical and surgical supplies used while inpatient in the facility
5. administration of infusions and transfusions. This does not include the cost of whole blood, packed red cells or blood donor fees.
6. devices that are an integral part of a surgical procedure. This includes items such as hip joints, skull plates and pacemakers. It does not include devices that are not directly involved in the surgery, such as artificial limbs, artificial eyes or hearing aids.

"Assistant Surgeon" – a physician trained in the appropriate surgical specialty who serves as the first assistant to another surgeon during a surgical procedure. When medically appropriate, the service of only one assistant per procedure is covered under the Plan.

"Attempt" – the initiation of a reproductive cycle with the expectation of implanting a fertilized ovum. The occurrence of either of the following events constitutes an attempt:

- commencement of drug therapy to induce ovulation, or
- operative procedures for the purpose of implantation of a fertilized ovum

"Cardiac Rehabilitation Program" – a recognized, multi-disciplinary program operated by a licensed facility that treats cardiovascular disease through cardiac rehabilitation treatment. The program must meet the generally accepted standards of cardiac rehabilitation.

"Cardiac Rehabilitation Treatment" – treatment of documented cardiovascular disease by a cardiovascular rehabilitation program that includes exercise and diet management in order to improve cardiovascular function.

"CIC (Catastrophic Illness Coverage)" – Plan participants can elect CIC (comprehensive) or non-CIC (non-comprehensive) coverage. CIC increases the benefits for most covered services to 100%, subject to

any applicable copays and deductibles. Enrollees without CIC pay higher deductibles and receive only 80% coverage for some services.

"Cognitive Rehabilitation or Cognitive Therapy" – treatment to restore function or minimize effects of cognitive deficits, including but not limited to those related to thinking, learning and memory.

"Coronary Artery Disease Secondary Prevention Program" – an approved established program for individuals with a diagnosis of coronary artery disease, offered by a specialized interdisciplinary team of clinicians, designed to reduce the effects of heart disease by lifestyle change, diet control, exercise, stress reduction and group support.

"Cosmetic Procedures/Services" – cosmetic services are those services performed mainly for the purpose of improving appearance. These services do not restore bodily function or correct functional impairment. Cosmetic services are not covered, even if they are intended to improve a member's emotional outlook or treat a member's mental health condition.

"Custodial Care" – a level of care that is chiefly designed to assist a person in the activities of daily living and cannot reasonably be expected to greatly restore health or bodily function.

"Dependent" – a Medicare-eligible individual who is:

1. The legal spouse (or former spouse if authorized by the GIC) of the covered employee or retiree
2. An unmarried child of a covered employee, retiree or surviving spouse by birth, legal adoption (upon placement of the child in the home), under custody pursuant to a court order, or under legal guardianship until the age of 19 years
3. An unmarried child who depends upon and lives with the covered employee, retiree or surviving spouse and for whom there is evidence of a regular parent-child relationship satisfactory to the GIC, until the age of 19 years
4. An unmarried child who upon becoming 19 years of age is mentally or physically incapable of earning his or her own living, proof of which must be on file with the GIC
5. A full-time student, as determined by the GIC, until the age of 24 years (at age 24, a full-time student may elect to continue coverage as an individual under the Commonwealth Indemnity Plan at 100% of the required premium. That student must file a written application with the GIC and the application must be approved by the GIC), or
6. A newborn child of a covered employee's, retiree's or surviving spouse's dependent son or daughter until the parent of such child ceases to be a dependent of such covered person, or the date the newborn child ceases to be a dependent, whichever occurs first.

"Durable Medical Equipment" – equipment designed primarily for therapeutic purposes or to extend function that can stand repeated use and is medically necessary and prescribed by a physician. Such equipment includes wheelchairs, crutches, oxygen and respiratory equipment. Personal items related to activities of daily living such as commodes and shower chairs are not covered.

"Early Intervention Services" – medically necessary services that include occupational, physical and speech therapy, nursing care and psychological counseling for children from birth until their third birthdays. These services

must be provided by persons licensed or certified under Massachusetts law, who are working in Early Intervention programs approved by the Department of Public Health.

"Emergency" – an emergency is an illness or medical condition, whether physical or mental, that manifests itself by symptoms of sufficient severity, including severe pain that in the absence of immediate medical attention could reasonably be expected by a prudent lay person, who possesses an average knowledge of health and medicine, to result in serious jeopardy to physical and/or mental health, serious impairment to bodily functions, serious dysfunction of any bodily organ or part, or, in the case of pregnancy, a threat to the safety of a member or her unborn child. Emergency treatment does not include Urgent Care. Emergency treatment may be rendered in a hospital, physician's office or other medical facility.

"Enteral Therapy" – prescribed nutrition that is administered through a tube that has been inserted into the stomach or intestines. Nutritional formulas and supplies used for enteral therapy are covered under the prescription drug plan.

"Experimental or Investigational Procedures" – a service that is determined by the Plan to be experimental or investigational; that is, inadequate or lacking in evidence as to its effectiveness, through the use of objective methods and study over a long enough period of time to be able to assess outcomes. The fact that a physician ordered it or that this treatment has been tried after others have failed does not make it medically necessary.

"Family Planning Services" – office visits and procedures for the purpose of contraception. Procedures include fitting for a diaphragm or cervical cap; the insertion, re-insertion, or removal of an IUD or Levonorgestrel (Norplant); and the injection of progesterone (Depo-Provera). FDA-approved contraceptive drugs and devices are available through your prescription drug plan.

"Home Health Care" – health services and supplies provided by a home health care agency on a part-time, intermittent or visiting basis. Such services and supplies must be provided in a person's place of residence (not an institution) while the person is confined as a result of injury, disease or pregnancy. To be considered for coverage, Home Health Care must be delivered by a Home Health Care Agency certified by Medicare.

"Home Health Care Plan" – a plan of care for services in the home ordered in writing by a physician. A Home Health Care Plan is subject to review and approval by the Plan.

"Home Infusion Company" – a company that is licensed as a pharmacy and is qualified to provide home infusion therapy.

"Home Infusion Therapy" – the administration of intravenous, subcutaneous or intramuscular therapies provided in the home setting. Subcutaneous and intramuscular drugs are available through your prescription drug plan.

"Hospice" – a public agency or a private organization which provides care and services for terminally ill persons and their families and is certified as such by Medicare.

"Hospital" – an institution that meets all of the following conditions:

1. is operated pursuant to law for the provision of medical care
2. provides continuous 24-hour-a-day nursing care
3. has facilities for diagnosis

4. has facilities for major surgery
5. provides acute medical/surgical care or acute rehabilitation or care
6. is licensed as an acute hospital, and
7. has an average length of stay of less than 25 days

The term "Hospital" includes free-standing ambulatory surgical centers operating pursuant to law.

The term "Hospital" does not include:

(a) rest homes
(b) nursing homes
(c) convalescent homes
(d) places for custodial care
(e) homes for the aged

Also see definition for "Other Inpatient Facilities."

"Hospital Stay" – the time a person is confined to a hospital and incurs a room and board charge for inpatient care other than custodial care.

"Incurred Date" – the date a service or supply is provided.

"Infertility" – the condition of a healthy individual who is unable to conceive or produce conception during a period of one year, except if this condition is the result of voluntary sterilization or the normally occurring aging process.

"Injury" – bodily injury sustained accidentally by external means.

"Manipulative Therapy" –hands-on treatment provided by a chiropractor or osteopathic or medical physician by means of direct manipulation or movement to relieve pain, restore function and/or minimize disability as a result of disease or injury to the neuromuscular and/or musculoskeletal system. Acupuncture, rolfing therapy and Shiatsu are not covered.

"Medically Necessary" – with respect to care under the Plan, means that the treatment will meet at least the following standards:

1. is adequate and essential for evaluation or treatment consistent with the symptoms, proper diagnosis and treatment appropriate for the specific member's illness, disease or condition as defined by standard diagnostic nomenclatures (DSM-IV or its equivalent ICD-9CM)
2. is reasonably expected to improve or palliate the member's illness, condition or level of functioning
3. is safe and effective according to nationally accepted standard clinical evidence generally recognized by medical professionals and peer reviewed publications, and
4. is the most appropriate and cost-effective level that can safely be provided for the specific member's diagnosed condition

"Medical Supplies or Equipment" – disposable items prescribed by physicians as medically necessary to treat disease and injury. Such items include surgical dressings, splints and braces.

"Non-Experimental Infertility Procedure" – a procedure recognized as generally accepted and/or non-experimental by the American Fertility Society and the American College of Obstetrics and Gynecology.

"Nursing Home" – an institution that:

1. provides inpatient skilled nursing care and related services, and

2. is licensed in any jurisdiction requiring such licensing, but
3. does not qualify as a Skilled Nursing Facility (SNF) as defined by Medicare

A home, facility or part of a facility does not qualify as a SNF or nursing home if it is used primarily for:

1. rest
2. the care of drug abuse or alcoholism
3. the care of mental diseases or disorders
4. custodial or educational care

"Occupational Injury/Disease" – an injury or disease that arises out of and in the course of employment for wage or profit (see Exclusions on page 38).

"Occupational Therapy" – Occupational therapy is skilled treatment that helps individuals achieve independence with activities of daily living after an illness or injury not incurred during the course of employment. Services include: treatment programs aimed at improving the ability to carry out activities of daily living; comprehensive evaluations of the home; and recommendations and training in the use of adaptive equipment to replace lost function.

"Off Label Use of a Prescription Drug" – the use of a drug that does not meet the prescribed indications as approved by the Food and Drug Administration (FDA).

"Orthotic" – an orthopedic appliance or apparatus used to support, align or correct deformities and/or to improve the function of movable parts of the body. An orthotic must be ordered by a physician, be custom fabricated (molded and fitted) to the patient's body, and be for use by that patient only.

"Other Inpatient Facilities" – includes the following hospitals/facilities:

1. skilled nursing facilities
2. chronic disease hospitals/facilities
3. transitional care hospitals/facilities
4. sub-acute care hospitals/facilities
5. long-term care hospitals/facilities
6. any inpatient facility with an average length of stay greater than 25 days

"Physical Therapy" – hands-on treatment provided by a licensed physical therapist by means of direct manipulation, exercise, movement or other physical modalities to relieve pain, restore function and/or minimize disability as a result of disease or injury to the neuromuscular and or musculoskeletal system or following the loss of a body part. Aerobic exercise, rolfing therapy and Shiatsu, sports conditioning/weight training, group therapy and other such treatments are not covered.

"Physician" – the term "physician" includes the following health care providers acting within the scope of their licenses or certifications:

1. physician
2. podiatrist
3. chiropractor
4. certified nurse midwife
5. dentist
6. optometrist

"Preferred Vendor" – a provider contracted by the Plan to provide certain services or equipment, such as lab services or durable medical equipment, at a higher benefit level than other providers.

"Prostheses" – items that replace all or part of a bodily organ or limb and which are medically necessary and are prescribed by a physician. Examples include breast prostheses and artificial limbs.

Plan Definitions

"Reasonable and Customary Charge" – a charge that does not exceed the general level of charges being made by others in a given geographic area where the charge is incurred when furnishing like or similar treatment, services or supplies.

"Reconstructive and Restorative Surgery" – surgery intended to improve or restore bodily function or to correct a functional physical impairment that has been caused by one of the following:

• a congenital anomaly, or

• a previous surgical procedure or disease

Restoration of a bodily organ that is surgically removed during treatment of cancer must be performed within five (5) years of surgical removal.

"Respite Care" – services rendered to a hospice patient in order to relieve the family or primary care person from caregiving functions. Respite care is covered in the home, hospital or in a skilled nursing facility or nursing home and is limited to a total of five (5) days.

"Skilled Care" – medical services that can only be provided by a registered or certified professional health care provider.

"Skilled Nursing Facility (SNF)" – an institution that:

1. is operated pursuant to law
2. is licensed or accredited as a skilled nursing facility if the laws of the jurisdiction in which it is located provide for the licensing or the accreditation of a skilled nursing facility
3. is approved as a skilled nursing facility for payment of Medicare benefits or qualified to receive such approval, if requested
4. is primarily engaged in providing room and board and skilled nursing care under the supervision of a physician
5. provides continuous 24-hour-a-day skilled nursing care by or under the supervision of a registered nurse (RN), and
6. maintains a daily medical record of each patient

A home, facility or part of a facility does not qualify as a skilled nursing facility or nursing home if it is used primarily for:

1. the care of drug abuse or alcoholism
2. the care of mental diseases or disorders
3. rest, or
4. custodial or educational care

"Spouse" – the legal spouse of the covered employee or retiree

"Surgical Procedure" – any of the following types of treatment:

1. a cutting procedure
2. suturing of a wound
3. treatment of a fracture
4. reduction of a dislocation
5. radiotherapy, excluding radioactive isotope therapy, if used in lieu of a cutting operation for removal of a tumor
6. electrocauterization
7. diagnostic and therapeutic endoscopic procedures
8. injection treatment of hemorrhoids and varicose veins, and
9. an operation by means of laser beam

"Temporomandibular Joint (TMJ) Disorder" – a syndrome or dysfunction of the joint between the jawbone and skull and the muscles, nerves and other tissues related to that joint.

"Urgent Care" – treatment that is provided as soon as the treatment can be arranged, but the treatment is not immediately necessary to prevent death or permanent impairment.

Urgent Care does not qualify as emergency treatment.

"Visiting Nurse Association" – an agency, certified by Medicare, which provides part-time, intermittent skilled nursing services and other home care services in a person's place of residence and is licensed in any jurisdiction requiring such licensing.

"Written Proof" – satisfactory proof, in writing, of the incurral of a claim.

General Provisions

This section describes the enrollment process for you and your eligible dependents; when coverage begins and ends; and continuing coverage when eligibility status changes.

Application for Coverage

You must apply to the GIC for enrollment in the Plan. Contact the senior unit at the GIC to obtain the appropriate forms.

To enroll newborns:
You must enroll that child within 31 days of the child's birth.

To enroll or add your dependents:
You must enroll each additional dependent when he or she becomes eligible. If you marry, you must enroll your spouse within 31 days of the marriage.

To enroll adopted children:
Adopted children must be enrolled within 31 days of placement in the home.

Full-time student coverage:
An unmarried dependent child who reaches age 19 is no longer eligible for coverage unless enrolled in an accredited school as a full-time student. In order to continue coverage for a full-time student, you must complete all of the following steps:

1. complete the initial written application sent to you by the Plan prior to the dependent's 19th birthday
2. complete subsequent verification forms sent to you by the Plan twice a year to verify continued full-time student status, and
3. return all the completed forms to the Commonwealth Service Center within 30 days of their receipt. If the forms are not received within 30 days, your dependent may have a gap in coverage.

If coverage for a student is interrupted for 24 or more consecutive months, the dependent is no longer eligible for coverage.

If you have questions about this process or need additional forms, please call 1-800-442-9300. You can also e-mail us from our web site at www.unicare-cip.com.

When Coverage Begins

Coverage under the Plan starts as follows:

For individuals applying during an annual enrollment period:
Coverage begins on the following July 1.

For dependents:
Coverage begins on the later of:

1. the date your own coverage begins, or
2. the date the person qualifies as your dependent

For new retirees, spouses and surviving spouses:
You will be notified by the GIC of the date on which coverage begins.

Continued Coverage

Your eligibility for these benefits continues if you are:

1. an employee of the Commonwealth
2. a Commonwealth retiree who is enrolled in Medicare Parts A and B
3. a spouse of a Commonwealth retiree who is enrolled in Medicare Parts A and B, or
4. a surviving spouse of a Commonwealth employee or Commonwealth retiree who is enrolled in Medicare Parts A and B

When Coverage Ends for Enrollees

Your coverage ends on the earliest of:

1. the end of the month covered by the last contribution toward the cost of your coverage
2. the end of the month in which you cease to be eligible for coverage
3. the date the enrollment period ends
4. the date of death, or
5. the date the Medicare Extension Plan terminates

When Coverage Ends for Dependents

A dependent's coverage ends on the earliest of:

1. the date your coverage under the Medicare Extension Plan ends
2. the end of the month covered by your last contribution toward the cost of such coverage
3. the date you become ineligible to have dependents covered
4. the date the enrollment period ends
5. the date the dependent ceases to qualify as a dependent
6. the date the dependent begins active duty in the armed forces of the United States
7. the date the dependent marries
8. the date of dependent's death
9. the date the Medicare Extension Plan terminates, or
10. the last day of the month in which the dependent turns age 19 unless he or she qualifies as a full-time student or handicapped dependent

Duplicate Coverage

No person can be covered by any other GIC health plan at the same time as:

1. both an employee, retiree or surviving spouse and a dependent, or
2. a dependent of more than one covered person (employee, retiree, spouse or surviving spouse)

Special Enrollment Condition

If you have declined the Medicare Extension Plan for your spouse or for your dependents because they have other health coverage, you may be able to enroll them during the Plan year if the other coverage is lost. Check with the Senior Unit at the GIC to obtain the appropriate enrollment forms.

Continuing Coverage

The provisions in this section explain how coverage may be continued or converted if eligibility status changes.

Continuing Health Coverage Due to Involuntary Layoff

If you are no longer eligible for coverage due to involuntary layoff, you may have coverage under the Medicare Extension Plan continued for 39 consecutive weeks. This coverage would apply to you and all of your dependents who are covered under the Plan at the time you are laid off.

In the event of involuntary layoff, the person who has the option to continue coverage must:

1. elect the continuance, in writing, within 30 days after the date eligibility for coverage ends, and
2. pay the full cost of the coverage to the GIC

Coverage will end on the earliest of:

1. the end of the month of 39 consecutive weeks following the date you cease to be eligible for coverage

2. the end of the month covered by the last contribution toward the cost of your coverage
3. the date the coverage ends
4. the date the Medicare Extension Plan terminates, or
5. in the case of a dependent, the date that dependent would cease to qualify as a dependent if you had remained eligible for the coverage

Option to Continue Coverage As a Deferred Retiree

You are eligible for deferred retirement if you:

1. have 10 or more years of full-time service (as determined by the State Retirement Board or your retirement board), and
2. are eligible for a state pension, and
3. are leaving your retirement monies in your retirement system

The person who chooses to continue health coverage as a deferred retiree must:

1. contact the GIC for enrollment information, and
2. pay the full cost of the coverage to the GIC

Coverage will end on the earliest of:

1. the end of the month covered by the last contribution toward the cost of your coverage
2. the date the coverage ends
3. the date the Commonwealth Indemnity Plan terminates, or
4. in the case of a dependent, the date that dependent would cease to qualify as a dependent if you had remained eligible for the coverage
5. the date you withdraw your monies from the retirement system

Continuing Health Coverage for Survivors

In the event of your death, your surviving spouse may continue coverage for himself or herself and all dependents covered under the Plan. If you have no surviving spouse, then your surviving dependent child or children may have such coverage continued until age 19.

In order to continue coverage, the person who has the option to continue must:

1. elect the continuation in writing within 30 days after the date of your death, and
2. make the required contribution toward the cost of coverage

Coverage for survivors will end on the earliest of these dates:

1. the end of the month in which the survivor dies
2. the end of the month covered by the last contribution toward the cost of the coverage
3. the date the coverage ends
4. the date the Medicare Extension Plan terminates
5. in the case of a dependent, the date that dependent would cease to qualify as a dependent, or
6. the date the survivor remarries

Option to Continue Coverage After Change in Marital Status

Your spouse will not cease to qualify as a dependent solely because a judgment of divorce or of separate support is granted. If that judgment is granted while the former spouse is covered as a dependent and states that coverage for the former spouse will continue, that person will continue to qualify as a dependent under the Medicare Extension Plan, provided family coverage continues and neither party remarries.

If you get divorced, you must notify the GIC and send them a copy of your divorce decree. If you or your former spouse remarry, you must also notify the GIC.

The former spouse will no longer qualify as a dependent after the earliest of these dates:

1. the end of the period specified in the judgment during which that person must remain eligible for coverage
2. the end of the month covered by the last contribution toward the cost of the coverage
3. the date that person remarries
4. the date you remarry. If that person is still covered as a dependent on this date, and the judgment gives that person the right to continue coverage at full cost after you remarry, then that person may either elect to:
   (a) remain covered separately for the benefits for which he or she was covered on that date, or
   (b) COBRA, or
   (c) have a converted policy issued to provide those benefits

For the purposes of this provision "judgment" means only a judgment of absolute divorce or of separate support.

Group Health Continuation Coverage Under COBRA

When you or your covered dependents are no longer eligible for coverage under the Medicare Extension Plan, you or your dependents may be eligible to continue coverage as provided by the Consolidated Omnibus Budget Reconciliation Act (a federal law known as COBRA). Under this law, the GIC must provide covered enrollees and their dependents who lose coverage under the Plan with the option to continue coverage for a limited period of time. This coverage must be identical to the current coverage provided under the Plan to similarly situated enrollees or dependents. The mandate is restricted to certain conditions under which coverage is lost and the election to continue must be made within a specified election period.

The table below shows the qualifying events that make you eligible for COBRA, and the maximum length of time coverage can be extended.

Qualifying Event	Maximum Continuation Period
Enrollee:	
• Termination of employment for any reason, except gross misconduct	18 months
• Loss of eligibility due to reduction in work hours	18 months
• Determination by the Social Security Administration (SSA) of disability that existed at the time of the qualifying event	29 months
Dependent Child:	
• Parent's termination of employment as stated above	18 months
• Parent's loss of eligibility due to a reduction in work hours	18 months
• Parent's death, divorce or legal separation	36 months
• Parent enrolls in Medicare	36 months
• Dependent ceases to satisfy Plan's eligibility requirements for dependent status	36 months
• Determination by the Social Security Administration (SSA) of disability that existed at the time of qualifying event. Must have been covered under the Plan at the time of the qualifying event.	29 months
Spouse:	
• Spouse's termination of employment as stated above	18 months
• Spouse's loss of eligibility due to a reduction in work hours	18 months
• Spouse's death, divorce or legal separation	36 months
• Spouse enrolls in Medicare:	
– spouse or ex-spouse under the age of 55	36 months
– spouse or ex-spouse age 55 or older	the date spouse or ex-spouse becomes entitled to Medicare

A child who is born or placed for adoption with you while you are covered under COBRA will be eligible to become a qualified beneficiary and can be added to family COBRA coverage upon notification and proof to the GIC of the birth or adoption.

If you are covered under COBRA and have been determined to be disabled by the Social Security Administration (SSA), you may be eligible to extend your coverage from 18 months to 29 months. You must submit a copy of the SSA determination to the GIC within 60 days of the date of the SSA determination letter and before the end of the original 18-month COBRA coverage period. Failure to notify the GIC and submit the required documentation within the 60 day period will disqualify you for the extension.

COBRA Eligibility Notification and Enrollment

Under COBRA, you have 60 days from the date you lose coverage due to one of the qualifying events described on page 54, to inform the GIC that you want to continue coverage. If you do not choose COBRA within the 60-day limit, your group health insurance coverage will end.

COBRA requires that the enrollee or a family member inform the GIC within 60 days of the date of the following events or the date on which coverage would be lost due to one of the following events:

1. an employee's termination or reduction in hours
2. death, divorce, legal separation or remarriage of a former spouse
3. Medicare enrollment, or
4. a child ending dependent status

If you have changed marital status or your address, please notify the Group Insurance Commission at P.O. Box 8747, Boston, MA 02114-8747.

Premium Payment under COBRA

COBRA payments are made directly to the GIC.

At the end of the continuation coverage, you have the option to enroll in an individual conversion health insurance policy.

Termination of Coverage under COBRA

Termination of COBRA occurs when the earliest of the following occurs:

1. maximum continuation period ends
2. covered enrollee or dependent fails to pay the premium
3. covered enrollee or dependent becomes a participant in another group health plan that does not impose a pre-existing condition exclusion
4. the covered member is no longer disabled if the coverage was extended to 29 months due to a disability.
5. the Commonwealth of Massachusetts no longer provides group health coverage to any of its employees or retirees.

Conversion to Non-group Health Coverage

Under certain circumstances, a person whose Medicare Extension Plan coverage is ending has the privilege to convert to non-group health coverage provided by UniCare.

A certificate for this non-group health coverage issued by UniCare can be obtained if:

1. employment for coverage purposes ends, except due to retirement, or
2. status changes to one that is not eligible for continued coverage under the Medicare Extension Plan

You cannot obtain a certificate of coverage if you are otherwise eligible under the Medicare Extension Plan, or if your coverage terminated for failure to make a required contribution

when due. In addition, no certificate of coverage will be issued in a state or country where UniCare is not licensed to issue it.

The certificate of coverage will cover you and your dependents who cease to be covered under the Medicare Extension Plan because your health coverage ends, and any child of yours born within 31 days after such coverage ends.

A certificate of coverage is also available to the following persons whose coverage under the Medicare Extension Plan ceases:

1. Your spouse and/or your dependents, if their coverage ceases because of your death
2. Your child, covering only that child, if that child ceases to be covered under the Medicare Extension Plan solely because the child no longer qualifies as your dependent
3. Your spouse and/or dependents if their coverage ceases because of a change in marital status

The following rules apply to the issuance of the certificate of coverage:

1. Written application and the first premium must be submitted within 31 days after the coverage under the Medicare Extension Plan ends.
2. The rules of UniCare for coverage available for conversion purposes at the time application for a certificate of coverage is received govern the certificate. Such rules include: the form of the certificate; its benefits; the individuals covered; the premium payable and all other terms and conditions of such certificate.
3. If delivery of the certificate is to be made outside of Massachusetts, it may be on such form as is offered in the state where such certificate is to be delivered.
4. The certificate of coverage will become effective on the day after coverage under the Medicare Extension Plan ends.
5. No evidence of insurability will be required.

UniCare will furnish details of converted coverage upon request.

Coordination of Benefits (COB)

You and your dependents may be entitled to receive benefits from more than one plan. For instance, you may be covered as a dependent under your spouse's plan in addition to coverage under your own plan, or your child may be covered under both plans. When you or your dependents are covered by two or more plans, one plan is identified as the primary plan for coordination of benefits (COB) and determining the order of payment. Any other plan is then the secondary plan.

If the Medicare Extension Plan is the primary plan, benefit payments will be made in accordance with the benefits payable under the Plan without taking the other plan's benefits into consideration. A secondary plan may reduce its benefits if payments were paid by the Medicare Extension Plan. If another plan is primary, benefit payments under the Medicare Extension Plan are determined in the following manner:

(a) The Medicare Extension Plan determines its covered expenses – in other words, what the Plan would pay in the absence of other insurance; then

(b) The Medicare Extension Plan subtracts the primary plan's benefits from the covered expenses determined in (a) above; and then

(c) The Medicare Extension Plan pays the difference, if any, between (a) and (b).

The term **"primary plan's benefit"** includes the benefit that would have been paid had the claim been filed with the other plan. For those plans that provide benefits in the form of services, the reasonable cash value of each service is considered as the charge and as the benefit payment. All COB is determined on a calendar year basis for that part of the year the person had coverage under the Plan. For the purposes of COB, the term **"plan"** is defined as any plan, including HMOs, that provides medical or dental care coverage including, but not limited to, the following:

- group or blanket coverage
- group practice or other group prepayment coverage, including hospital or medical services coverage
- labor-management trusteed plans
- union welfare plans
- employer organization plans
- employee benefit organization plans
- coverage required or provided by law or government programs, except Medicaid. But, such coverage will not be deemed a plan if expenses for which benefits are payable under such coverage are excluded from benefits under Medicare Extension Plan coverage
- automobile no-fault coverage

The term "plan" does not include school-accident type plans, or coverage that you purchased on a non-group basis.

Determining Order of Coverage

Following are the rules by which the Medicare Extension Plan and most other plans determine order of payment – that is, which plan is the primary plan and which plan is the secondary plan:

(a) The plan without a COB provision is primary.

(b) The plan that covers the person as an employee, member, or retiree (that is other than a dependent) determines benefits before the plan that covers the person as a dependent.

(c) The order of coverage for a dependent child who is covered under both parents' plans is determined as follows:

1. The primary plan is the plan of the parent whose annual birthday falls first in the calendar year; or
2. If both parents have the same birthday, the primary plan is the plan that has covered a parent for the longest period of time.

This is called the **"birthday rule."** However, if the other plan has a rule based on the gender of the parent, and, if the plans do not agree on the order of coverage, the rules of the other plan will determine the order.

(d) The order of coverage for dependent children who are covered under more than one plan, and whose parents are divorced or separated, is determined in the following order:

1. first, the plan of the parent who is decreed by the court as financially responsible for the health care expenses of the child
2. second, if there is no court decree, the plan of the parent with custody of the child
3. third, if the parent with custody of the child is remarried, the plan of the step-parent

4. finally, the plan of the parent who does not have custody of the child

(e) The plan that covers a person as an active employee (that is, someone who is not laid off or retired) determines benefits for that person and his or her dependents before the plan that covers that same person as a retiree.

This is called the **"active before retiree"** rule. However, if the other plan's rule is based on length of coverage, and, if the plans do not agree on the order of coverage, the rules of the other plan will determine the order.

If none of the above rules can be applied when trying to determine the order of coverage, the plan that has covered the person longer determines benefits before the plan that has covered that same person for the shorter period of time.

Right to Receive and Release Information

In order to fulfill the terms of this COB provision or any other provision of similar purpose:

- a claimant must provide the Plan with all necessary information
- the Plan may obtain from or release information to any other person or entity

Facility of Payment

A payment made under another plan may include an amount that should have been paid under the Medicare Extension Plan. If it does, the Medicare Extension Plan may pay that amount to the organization that made the payment. That amount will be treated as if it were a benefit payable under the Medicare Extension Plan. The Medicare Extension Plan will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means the reasonable cash value of the benefits provided in the form of services.

Right of Recovery

If the amount of payments made by the Medicare Extension Plan is more than it should have been under the COB provision, the Plan may recover the excess from one or more of the following:

- the persons it has paid or for whom it has paid
- insurance companies, or
- other organizations

The "amount of payments made" includes the reasonable cash value of any benefits provided in the form of services.

Commonwealth Indemnity Plan
Administered by UNICARE

Prescription Drug Plan

Administered By:
EXPRESS SCRIPTS®

Description of Benefits

Prescription Drug Plan

Express Scripts is the pharmacy benefit manager for your prescription drug plan. If you have any questions about your prescription benefits, contact the Express Scripts Customer Service Call Center at 1-877-828-9744 (TDD: 1-800-842-5754).

About Your Plan

Your prescription drug plan uses a three tier copayment design.

The three tier design maintains a broad choice of covered drugs for patients and their physicians to choose from, while providing an incentive to use medications that are safe, effective and less costly. Frequently there is more than one prescription drug that your physician could prescribe for a particular illness or condition. Talk with your physician about your options to determine the best choice for you.

Generics Preferred

If your physician prescribes a brand name drug for which an FDA-approved generic equivalent is available, you will be responsible for the full difference in price between the brand and the generic drug, plus the generic copay.

Step Therapy

In some cases, your Plan requires the use of less expensive first-line prescription drugs before the Plan will pay for more expensive second-line prescription drugs. First-line prescription drugs are safe and effective medications used for the treatment of a medical condition or disease. Your prior claims history will show if first-line prescription drugs have been used before, allowing the more expensive medication to be approved. If a first-line prescription drug has been used previously, and has proven to be ineffective, a more expensive second-line prescription drug may be used. In certain situations a member may be granted a prior authorization for a second-line prescription drug if specific medical criteria have been met without the trial of a first-line prescription drug.

Current examples of second-line prescription drugs requiring Step Therapy:
Accupril®, Altace®, Avapro®, Bextra®, Celebrex®, Celexa®, Cozaar®, Diovan®, Enbrel®, Glucophage XR®, Nexium®, Paxil®, Prevacid®, Prilosec®, Protonix®, Singulair®, Vioxx® and Zoloft®.

This list may change during the plan year.

How to Use the Program

Retail

- Bring your Express Scripts ID card and your prescription(s) to a participating Express Scripts pharmacy. Pharmacy locations are available by contacting the Express Scripts Customer Service Call Center at 1-877-828-9744 (TDD: 1-800-842-5754) or through the Express Scripts web site at: www.express-scripts.com.

So that your pharmacist has all the necessary information to process a claim, please follow the steps outlined below:

- You (or your family member) should present your Express Scripts member ID Card to your pharmacist each time you fill or refill a prescription.
- If you do not have your ID Card, you can provide your pharmacist with the card-holder's Social Security or GIC ID number, and the group number which is GICA.
- The pharmacist also will be able to verify eligibility by contacting the Express Scripts Pharmacy Help Desk at 1-800-824-0898 (TDD: 1-800-842-5754).

If the pharmacy you are currently using is not participating in the Express Scripts network, you will need to transfer your prescription to an Express Scripts participating pharmacy. To do so, simply contact your current pharmacy and request a prescription transfer.

Retail (In-Network) Copayments

Retail Pharmacy *up to 30 days supply*	Member Copay
Tier 1: Generic drug	$7.00
Tier 2: Preferred brand name drug	$20.00
Tier 3: Non-Preferred brand name drug	$40.00*

**Additional charges will apply if the drug has a generic equivalent*

Mail

For prescriptions that you will take over an extended period of time, Express Scripts' convenient mail order and Internet service provides substantial savings.

To Begin Using Mail Service

- Obtain a 90 day prescription from your physician. (Please insure you have a 30-day supply on hand.)
- Clearly write your full name, address and Social Security or GIC ID number on the original prescription.
- Complete the patient profile included with your ID Card packet. Patient profiles are also available by contacting the Express Scripts Customer Service Call Center at 1-877-828-9744 (TDD: 1-800-842-5754).
- Mail the patient profile along with your original prescription, and appropriate copay, in the envelope included with the ID Card packet or available by contacting the Express Scripts Customer Service Call Center at 1-877-828-9744 (TDD: 1-800-842-5754).

To Obtain Mail Service Refills

Mail service prescription(s) refills are available by mailing in the refill slip, which you will receive with your first Express Scripts order. Refills are also available by contacting the Express Scripts Customer Service Call Center at 1-877-828-9744 (TDD: 1-800-842-5754) or through www.express-scripts.com.

Mail Service Copayments

Mail Order *up to 90 days supply*	Member Copay
Tier 1: Generic drug	$14.00
Tier 2: Preferred brand name drug	$40.00
Tier 3: Non-Preferred brand name drug	$70.00*

**Additional charges will apply if the drug has a generic equivalent*

Prescription Drug Plan

Claim Forms

Retail purchase(s) out of the country or in-network purchases without the use of your ID Card are covered as follows:

Type of Claim	Reimbursement
Claims for prescriptions for enrollees who reside in a nursing home or live or travel outside the U.S. or Puerto Rico.	Claims will be reimbursed at the full cost submitted less the applicable copayment.
Claims for purchases at a participating (in-network) pharmacy without a drug card.	Claims incurred within 30 days of the enrollee's eligibility effective date will be covered at full cost minus the applicable copayment. *-or-* Claims incurred more than 30 days after the enrollee's eligibility effective date will be reimbursed at a discounted cost minus the applicable copayment.

Commonly Used Terms

Generic Drug

Generic drugs are drugs for which the patent has expired, allowing other manufacturers to produce and distribute the product under its chemical name. Generics are essentially a chemical copy of their brand-name equivalents. The color or shape may be different, but the active ingredients must be the same. The Express Scripts formulary contains only FDA-approved generic medications.

Brand Name Drug

The brand name is the trade name under which the product is advertised and sold, and is protected by patents so that it can only be produced by one manufacturer for 17 years. Once a patent expires, other companies may manufacture a generic equivalent, providing they follow stringent FDA regulations for safety.

Preferred Brand Name Drug

A preferred brand name drug, also known as a formulary drug, is a medication that has been reviewed and approved by a carefully selected group of physicians and pharmacists for formulary inclusion based on its proven clinical and cost effectiveness.

Non-Preferred Brand Name Drug

A non-preferred brand name drug, or non-formulary drug, is a medication that has been reviewed by the same team of physicians and pharmacists who determined that an alternative drug that is clinically equivalent and more cost effective is available. These designations may change, as new clinical information becomes available.

Formulary

A formulary is a list of recommended prescription medications that is created, reviewed and continually updated by a team of physicians and pharmacists. The formulary contains a wide range of generic and brand name preferred products that have been approved by the Food and Drug Administration (FDA). The formulary applies to medications that are dispensed in both the retail pharmacy and mail service settings. The formulary is developed and maintained by Express Scripts.

Off-Label Use of a Prescription Drug

The off-label use of a prescription drug is the use of a drug for reasons not approved by the FDA.

Participating Pharmacy (In-Network)

A participating pharmacy is a pharmacy in the Express Scripts nationwide network. All chains and most independently owned pharmacies participate.

Prescription Drug

A prescription drug is any medical substance, the label of which under the Federal Food, Drug, and Cosmetic Act, must bear the legend: "Caution Federal Law prohibits dispensing without a prescription." The term prescription drug includes allergy extracts and insulin.

Prior Authorization

Prior Authorization means proof of medical necessity is required before a prescription for certain drugs will be paid by the plan. The purpose of prior authorization is to prevent misuse and the off-label use of expensive and potentially dangerous drugs.

Drugs that currently require Prior Authorization:

- Cerezyme®
- Aranesp®, Epogen®, Procrit®
- Weight Loss Medications
- Growth Hormones
- For members over the age of 35: Retin A®, Differin®, Axita®
- For members over the age of 18: Dexedrine®, Desoxyn®, Adderall®
- Prolastin®
- Botox®
- Lamisil®, Sporanox®

This list may change during the plan year.

Drug Utilization Review Program

Each prescription drug purchased through this program is subject to utilization review. This process evaluates the prescribed drug to determine if any of the following conditions exist:

- Adverse drug-to-drug interaction with another drug purchased through the program;
- Duplicate prescriptions;
- Inappropriate dosage and quantity; or
- Early refill of a prescription.

If any of the above conditions exist, medical necessity must be determined before the prescription drug can be processed.

Exclusions and Limitations

Benefits exclude drugs for off-label use, unless medically necessary for the care and treatment of an injury, illness or pregnancy. Additional exclusions:

- Smoking cessation programs or medications
- Dental preparations
- Over-the-counter drugs (with the exception of diabetic supplies)
- Vitamins or minerals prescribed in the absence of a medical condition (with the exception of prenatal vitamins)
- Prescriptions for cosmetic purposes

Quantities of some medications may be limited. Current examples include Imitrex®, Lamisil®, Maxalt®, Prevacid®, Prilosec®, Relenza®, Sporanox®, Tamiflu®, Viagra® and Zomig®.

This list is subject to revision.

Only medications covered under your benefit plan are included.

Claims Inquiry

If you believe your claim was incorrectly denied or you have questions about a prescription, call Express Scripts Customer Service Call Center at 1-877-828-9744. The TDD number is 1-800-842-5754.

Appeal Rights for Prior Authorization Denials

Denials of request for Prior Authorization may be appealed by having your physician send a letter explaining why the product is medically necessary for you. This letter should be sent to Express Scripts, Prior Authorization, PO Box 39842, Bloomington, MN 55439-0842. Submission of appeal is not a guarantee of coverage.

Health and Prescription Information

Health and prescription information about members and dependents is used by Express Scripts to administer your benefits. As part of the administration, Express Scripts may report health and prescription information to the administrator or sponsor of your benefit plan. Express Scripts also uses that information and prescription data gathered from claims nationwide for reporting and analysis without identifying individual patients.

Commonwealth Indemnity Plan
Administered by UNICARE

United Behavioral Health

Mental Health, Substance Abuse Services and Enrollee Assistance Programs

Description of Benefits

UNITED BEHAVIORAL HEALTH

PART I – How to Use This Plan

A Comprehensive Plan Designed with Your Well-Being in Mind

As a covered person under the Medicare Extension Plan, you are automatically enrolled in the mental health and substance abuse benefits program as well as the Enrollee Assistance Program (EAP) administered by United Behavioral Health. These programs offer you easy access to a broad range of services – from assistance with day-to-day concerns (e.g., legal and financial consultations, workplace-related stress, child-care and elder-care referrals) to more serious mental health and substance abuse needs, including assistance in a psychiatric emergency. By offering effective, goal-focused care delivered by a network of highly qualified providers, this program is designed to improve well-being and functioning as quickly as possible.

United Behavioral Health (UBH) is administering the benefits under this program on behalf of the insurer, UnitedHealthcare (UHC).

Let Us Show You the Benefits

The following describes your mental health, substance abuse and EAP benefits under the UBH plan. Please read it carefully before you seek care to ensure that you receive maximum benefits. The chart on pages 74-75 provides a brief overview of your benefits; however, it is not a detailed description. The detailed description of your benefits is found in Part III on pages 76-78. Words in italics throughout this description are defined in the "Definitions" section in Part II.

How to Ensure Maximum Benefits

In order to receive maximum benefits and reduce your out-of-pocket expenses, there are two important steps you need to remember:

Step 1: **Call UBH for *precertification* before you seek mental health, substance abuse or EAP services; and**

Step 2: **Use a provider or facility from the UBH network.**

UBH offers you a comprehensive network of resources and experienced providers from whom to obtain mental health, substance abuse and EAP services. All UBH *network providers* have been reviewed by UBH for their ability to provide quality care. If you receive care from a provider or facility that is not part of the UBH network, your benefit level will be lower than the network level. These reduced benefits are defined as *out-of-network benefits*. **You must call UBH to precertify your care, even when using out-of-network services. Only out-of-network outpatient care does not need to be precertified. If you fail to call UBH to precertify your care, you may be charged a penalty, and your benefits may be reduced. Benefits will be denied if your care is considered not to be a *covered service***. A full description of your network and out-of-network benefits begins on page 77.

Before You Use Your Benefits

Precertification

Precertification is the first step to obtaining your mental health, substance abuse and EAP benefits. To receive EAP services or before you begin mental health and substance abuse care, call UBH toll free at 1-888-610-9039 (TDD: 1-800-842-9489).

A trained UBH clinician will answer your call 24 hours a day, seven days a week, verify your coverage and refer you to a specialized EAP resource or a *network provider*. All *UBH clinicians* are experienced professionals with master's degrees in psychology, social work, or a related field. A *UBH clinician* will immediately be available to assist you with routine matters or in an emergency. If you have specific questions about your benefits or claims, call a customer service representative toll free from 9 a.m. to 8 p.m. Eastern Time at 1-888-610-9039 (TDD: 1-800-842-9489).*

Based on your specific needs, the UBH clinician will *precertify* visits if you are eligible for coverage at the time of your call, and provide you with the names of several EAP, mental health, or substance abuse providers who match your request (e.g., provider location, gender, or fluency in a second language). UBH maintains an extensive database of information on every provider in the network. A directory of UBH providers can be found on the UBH web site, www.liveandworkwell.com (access code 10910). After *precertification*, you can then call the provider directly to schedule an appointment. If you need assistance, a UBH clinician can help you in scheduling an appointment. The UBH clinician can also provide you with a referral for legal, financial, or dependent care assistance or community resources, depending on your specific needs.

Emergency Care

Emergency care is required when a person needs immediate clinical attention because he or she presents a real and significant risk to him/herself or others. In a life-threatening emergency, you and/or your covered dependents should seek care immediately at the closest emergency facility. You, a family member or your provider must call UBH **within 24 hours** of an emergency admission to notify UBH of the admission. Although a representative may call on your behalf, it is always the covered person's responsibility to ensure that UBH has been notified. If UBH is not notified of the admission, you will not be eligible for maximum benefits or benefits may be denied if it is not deemed to be a covered service. UBH staff is available 24 hours a day, seven days a week, to assist you and/or your covered family members.

Urgent Care

There may be times when a condition shows potential for becoming an emergency if not treated immediately. In such urgent situations, our providers will have an appointment to see you within 24 hours of your initial call to UBH. Call 1-888-610-9039 toll free (TDD: 1-800-842-9489) for assistance.

Routine Care

Routine care is for conditions that present no serious risk, and are not in danger of becoming an emergency. For routine care, *network providers* will have an appointment to see you within three days of your initial call to UBH. Call 1-888-610-9039 toll free (TDD: 1-800-842-9489) for assistance.

Enrollee Assistance Program

Your Enrollee Assistance Program benefit provides access to a range of resources, as well as focused, confidential, short-term counseling to treat problems of daily living (e.g., emotional, marital or family problems, legal disputes, or financial difficulties). The EAP benefit provides counseling and other professional services to you and your family members who are experiencing problems disrupting your personal and professional lives (e.g., reaction to international events, community trauma). The EAP can also provide critical incident response and on-site behavioral health-related consultations and seminars for state agencies.

* As part of UBH's quality control program, supervisors monitor random calls to UBH's customer service department, but not the clinical department.

Confidentiality

When you use your EAP, mental health, and substance abuse benefits under this plan, you are consenting to the release of necessary clinical records to UBH for *case management* and benefit administration purposes. Information from your clinical records will be provided to UBH only to the minimum extent necessary to administer and manage the care provided when you use your mental health, substance abuse and EAP benefits, and in accordance with state and federal laws. All of your records, correspondence, claims, and conversations with UBH staff are kept **completely confidential** in accordance with federal and state laws. No information may be released to your supervisor, employer, or your family without your written permission, and no one will be notified when you use your EAP, mental health, and substance abuse benefits. UBH staff must comply with a strict confidentiality policy.

Complaints

If you are not satisfied with any aspect of the UBH program, we encourage you to call UBH toll free at 1-888-610-9039 (TDD: 1-800-842-9489) to speak with a customer service representative. The UBH customer service representative resolves most complaints during your initial call. Complaints that require further research are reviewed by representatives of the appropriate departments at UBH, including clinicians, claims representatives, administrators, and other management staff who report directly to senior corporate officers. We will respond to all complaints within five (5) days. Your comments will help us correct any problems and provide better service to you and your dependents. If the resolution of your complaint is unsatisfactory to you, you have the right to file a formal complaint in writing within 60 days of the date of our telephone call or letter of response. Please specify dates of service and additional contact with UBH and include any information you feel is relevant. Formal complaints will be responded to in writing within 30 days. Send formal complaints to:

United Behavioral Health
Post Office Box 32040
Oakland, CA 94604-3340

Appeals (Grievance)

Your Right to an Internal Appeal (Grievance)

If you disagree with an adverse determination made by United Behavioral Health, you have the right to request an internal appeal review of that determination. United Behavioral Health provides one level of internal review. You are then eligible for an External Review Process if you still disagree with the results of the internal review.

An adverse determination is a determination by United Behavioral Health to deny, reduce, modify or terminate benefits for inpatient admission, continued inpatient stay, or any other behavioral health care service, for failure to meet the requirements for a *covered service.*

How to Initiate a First Level Internal Appeal (Grievance) Review

You or your authorized representative may submit an appeal request in writing, by calling the UBH toll-free telephone number or using the fax number, both of which are listed below. You have up to 180 days from the date you received the adverse determination letter to request a first level internal appeal. Send written requests to:

United Behavioral Health, Appeals Unit
Post Office Box 32040
Oakland, CA 94604-3340
Fax: 1-415-547-6259
1-800-888-2998, extension 5182

Appeal requests should include:

- the member's name, Social Security Number, and group policy number;
- the service which is the subject of the adverse determination;
- the reasons why you feel benefit coverage should be approved;
- any available medical information to support your reasons for reversing the adverse determination; and
- a completed authorization release, enclosed, to enable UBH to review your medical information.

You will receive a written acknowledgement of your appeal request within five (5) days of receipt of your written request. Oral requests will be documented and a copy will be forwarded to you within 48 hours of receiving your oral request.

Internal Appeal (Grievance) Review

An individual who did not participate in the adverse determination will review your appeal. This individual will be an actively practicing health care professional in the same or similar specialty that typically provides the treatment that is the subject of the appeal. United Behavioral Health will notify you or your authorized representative of the decision in writing within 30 days of receipt of your oral or written appeal.

An expedited internal review is available if you are receiving ongoing treatment or services in a hospital at the time of the adverse determination. You have the right to receive coverage of the disputed treatment or service until the completion of the internal appeal process. You or your authorized representative may request an expedited internal appeal by calling the toll-free number listed in the "How to Initiate the First Level Internal Appeal (Grievance)" section above.

A determination will be made and verbal notice provided within 24 hours and a written notification will follow to you and your physician within **one business day**. The written notice will be provided prior to the anticipated discharge. If you are dissatisfied with the outcome of the determination, you have the right to an expedited external review and the right to request continuation of coverage for the services. Please refer to the section below titled "External Review Process" for instructions.

If you have a terminal illness and you disagree with an adverse determination made by United Behavioral Health, you have the right to request an expedited internal appeal review of that determination.

External Review Process

You or your authorized representative or the attending provider may request an external review of an adverse determination that was a result of the internal appeal review. You or your authorized representative may request access to any medical information in the possession or control of the carrier relating to the insured. In order to request an external review, you must:

- Submit your request in writing within 45 days of your receipt of the adverse determination resulting from the internal review
- Complete the Massachusetts Request for External Appeal form and include the signed authorization of release of medical records

- Submit the form and appropriate fee to the Office of Patient Protection and include a copy of the written adverse determination notice resulting from the internal review to:

The Commonwealth of Massachusetts
Department of Public Health
Office of Patient Protection
250 Washington Street, 2nd Floor
Boston, MA 02108

You have the right to request an expedited external review. This request must be in writing from a physician, stating that delay in providing or continuing health care services, which are the subject of a final adverse determination, would pose a serious and immediate threat to the health of the insured.

The Office of Patient Protection will screen your request for an appeal within 48 hours of receipt for expedited requests, and five (5) business days of receipt for all other requests. Notification of ineligible requests shall be communicated to the member, the member's authorized representative and United Behavioral Health within 72 hours of receipt for an expedited request; and within 10 business days of receipt for all other requests and shall include the reason for the ineligible determination.

If your request is accepted, United Behavioral Health will forward the member's medical and treatment records and a copy of the evidence of coverage applicable to the member, to the external review agency assigned by the Office of Patient Protection within three (3) business days or within 24 hours for expedited requests.

For non-expedited reviews, the external review agency will make a decision within 60 business days of receipt of the referral from the Office of Patient Protection. For expedited reviews, the external review agency will make a decision within five (5) business days of receipt from the Office of Patient Protection. The decision will be in writing, will identify the decision, set forth the medical and scientific reasons for the decision and will be binding. If additional time is needed, the external review agency may extend the time period for an additional 15 business days and will notify all parties of that extension.

How to Contact the Office of Patient Protection at the Department of Public Health

You may contact the Department of Public Health with any questions at: 1-800-436-7757 or via FAX at 1-617-624-5046. You may also access the Department of Public Health's Web Site for additional copies of the required forms at: **http://www.state.ma.us/dph/opp**.

Filing Claims

Network providers and facilities will file your claim for you. You are financially responsible for *deductibles* and *copayments*.

Out-of-network providers are not required to process claims on your behalf; you must submit the claims yourself. You are responsible for all *coinsurance* and *deductibles*. Send the *out-of-network provider's* itemized bill and a completed CMS 1500 (formerly HCFA 1500) claim form and your Medicare Explanation of Benefits (EOMB), along with your name, address and GIC ID number to:

United Behavioral Health
GIC Claims
Post Office Box 30755
Salt Lake City, UT 84130-0755

The CMS 1500 form is available from your provider. Claims must be received by UBH

within 15 months of the date of service for you or a covered dependent. You must be eligible for coverage on the date you received care. All claims are confidential.

Coordination of Benefits

All benefits under this plan are subject to coordination of benefits, which determines whether your mental health and substance abuse care is partially or fully covered by another plan. UBH may request information from you about other health insurance coverage in order to process your claim correctly.

For More Information

UBH customer service staff is available to help you. Call 1-888-610-9039 toll free (TDD: 1-800-842-9489) for assistance Monday through Friday, from 9 a.m. to 8 p.m. Eastern Time.

PART II – Benefit Highlights

Definitions of UBH Terms

Allowed Charges means charges conform to UBH negotiated fee maximums or reasonable and customary rates. If the cost of treatment for out-of-network care exceeds the *allowed charges*, the covered person may be responsible for the difference.

In Massachusetts, if you choose to use a provider other than a *network provider*, you are responsible for the coinsurance amounts up to the allowed charge. Providers of services in Massachusetts are prohibited by law from billing you for amount in excess of Plan determined amounts.

Outside Massachusetts, if you chose to use a provider other than a *network provider*, you are responsible for amounts in excess of the allowed charge. Amounts in excess of the allowed charge are not applied toward satisfying the *deductible*, *coinsurance* or *out-of-pocket maximum*.

Appeal (Grievance) means a formal request for UBH to reconsider any adverse determination/denial of coverage, either concurrently or retrospectively, for admissions, continued stays, levels of care, procedures, or services.

Case Management means a system of *continuing review* by a UBH clinical case manager, using objective clinical criteria, to determine if treatment is appropriate and is a *covered service* according to the plan of benefits for a covered diagnostic condition.

Coinsurance means the limit of coverage by the plan to a certain percentage of provider costs and fees, such as 80%. The remaining percentage is paid by the covered person. The provider is responsible for billing the member for the remaining percentage.

Complaint means a verbal or written statement of dissatisfaction arising from a perceived adverse administrative action, decision, or policy by UBH.

Continuing Review/Concurrent Review means an assessment of the care while it is being delivered and the proposed treatment plan for future care, conducted at periodic intervals by a clinical case manager to determine the appropriateness of continued care.

Coordination of Benefits (COB) means a methodology which determines the order and proportion of insurance payment when a covered person has coverage through more than one insurer. The regulations define which organization has primary responsibility for payment and which organization has secondary responsibility for any remaining charges not covered by the "primary plan."

Copayment means a fixed dollar amount that a covered person must pay out of his or her own pocket.

Covered Services are services and supplies provided for the purpose of preventing, diagnosing or treating a behavioral disorder, psychological injury or substance abuse addiction and which are described in the section titled "What This Plan Pays," and not excluded under the section titled "What's Not Covered – Exclusions."

Cross Accumulation means the sum of applicable expenses paid by a covered person to determine whether a *deductible* or *out-of-pocket maximum* has been reached.

Deductible means the designated amount that a covered person must pay for any charges before insurance coverage applies.

Intermediate Care means care that is more intensive than traditional outpatient treatment but less intensive than 24-hour hospitalization. Some examples are residential treatment, group homes, halfway houses, therapeutic foster care, day or partial hospital programs, or structured outpatient programs.

Network Provider is a provider who participates in the United Behavioral Health network.

Non-Notification Penalty means the amount charged when you fail to *precertify* care. It does not count towards the *out-of-pocket maximum*.

Out-of-Network Provider is a provider who does not participate in the United Behavioral Health network.

Out-of-Pocket Maximum means the maximum amount you will pay in *coinsurance* and *copayments* for your mental health and substance abuse care in one calendar year. When you have met your *out-of-pocket maximum*, all care will be covered at 100% of the *allowed charge* until the end of that calendar year. This maximum does not include the *non-notification penalty*, charges for out-of-network care that exceed the maximum number of covered days or visits, out-of-network outpatient service costs, the out-of-network calendar year *deductible*, the out-of-network inpatient *deductible*, charges for care not deemed to be a *covered service*, and charges in excess of UBH's *allowed charges*.

Precertification (Precertify) is the process of registering for services with UBH prior to seeking mental health, substance abuse and EAP care. All *precertification* is performed by *UBH clinicians*.

UBH Clinician refers to the staff member who *precertifies* mental health, substance abuse and EAP services. *UBH clinicians* must have the following qualifications: Master's degree in psychology, social work, or a related field; three or more years of clinical experience; Certified Employee Assistance Professionals (CEAP) certification or eligibility; and a comprehensive understanding of the full range of EAP services for employees and employers, including workplace and personal concerns.

Words in italics are defined in Part II

Mental Health, Substance Abuse and EAP Services

Benefits Chart

The following chart summarizes certain benefits available to you. Be sure to read Part III which describes your benefits in detail and notes some important restrictions. Remember, in order to receive the maximum benefits, you must *precertify* your care with UBH before you begin treatment. For assistance, call toll free, 24 hours a day, seven days a week: 1-888-610-9039 (TDD: 1-800-842-9489).

Covered Services	Network Benefits	Out-of-Network Benefits
Annual Deductible	None	$100 per person (a, b)
Out-of-Pocket Maximum	$1,000 per person (a)	$3,000 per person (a)
Benefit Maximum	Unlimited	See *Covered Service* Benefit Maximum
Inpatient Care		
Deductible	$50 per calendar quarter	$150 per admission (applies after annual deductible is met).
Mental Health General Hospital	Full Coverage	80% of *allowed* charges
Psychiatric Hospital	Full Coverage	80% of *allowed* charges up to 60 days/year
Substance Abuse (c) General Hospital	Full Coverage	80% of *allowed* charges up to 30 days/year
Substance Abuse Facility	All hospital care must be *precertified*. Emergency admissions must be *precertified* within 24 hours to receive maximum benefits. *Non-notification penalty* for failure to *precertify* care is $200. *Non-notification penalty* does not count toward *out-of-pocket maximums*.	
Intermediate Care (d) (Care that is more intensive than traditional outpatient services, but less intensive than 24-hour hospitalization. Examples are residential treatment, group homes, halfway houses, therapeutic foster care, day/partial hospitals, or structured outpatient programs)	Full Coverage	80% of *allowed* charges

Mental Health, Substance Abuse and EAP Services

Covered Services	Network Benefits	Out-of-Network Benefits
Outpatient Care (d) – Mental Health, Substance Abuse and Enrollee Assistance		
First Four Visits	Full Coverage	80% of *allowed* charges
Visits 5 and over (Individual) Visits 5 and over (Group)	After $10 copay, full coverage After $5 copay, full coverage	80% of *allowed* charges Maximum: 15 visits per year for mental health and substance abuse services. No coverage for out-of-network Enrollee Assistance Program Services
	Network costs paid by member count toward *out-of-pocket maximum*.	Out-of-Network care utilized to satisfy the annual deductible counts toward the 15 visit maximum Out-of-Network costs paid by member do not count toward *out-of-pocket maximum*.
	EAP *non-notification penalty* reduces benefit to zero; no benefits paid	
Medication Management: 15-30 minute psychiatrist visit	After $5 copay, full coverage	80% of *allowed* charges; applies towards annual outpatient out-of-network maximum
In-Home Health Care	Full Coverage	80% of *allowed* charges; applies towards annual outpatient out-of-network maximum
Drug Testing (as an adjunct to Substance Abuse treatment)	Full Coverage	No Coverage
	Non-notification penalty reduces benefit to zero: no benefits paid.	
Provider Eligibility – provider must be licensed in one of these disciplines.	MD Psychiatrist, PhD, PsyD, EdD, MSW, MSN, LICSW, RNMSCS, MA(e)	MD Psychiatrist, PhD, PsyD, EdD, MSW, MSN, LICSW, RNMSCS, MA(e)

(a) Separate from medical deductible and medical out-of-pocket maximum. Network and out-of-network out-of-pocket maximums do not *cross accumulate.*
(b) *Cross accumulates* with all out-of-network mental health and substance abuse benefit levels.
(c) Substance abuse rehabilitation program: Members are reimbursed for inpatient and outpatient copays if they complete inpatient and post-discharge care.
(d) Treatment that is not *precertified* receives out-of-network reimbursement.
(e) Massachusetts independently licensed providers; psychiatrists, psychologists, licensed clinical social workers, psychiatric nurse clinical specialists and allied mental health professionals.

What This Plan Pays

The Plan pays for the following services:

- **Outpatient Care** – Individual or group sessions with a therapist, usually conducted once a week, in the provider's office or facility.
- **Intermediate Care** – Care that is more intensive than traditional outpatient services, but less intensive than 24-hour hospitalization. Some examples are residential treatment, group homes, halfway houses, therapeutic foster care, day/partial hospitals, or structured outpatient programs.
- **In-Home Care** – A licensed mental health professional visits the patient in his or her home.
- **Inpatient Care** – Treatment in a hospital or substance abuse facility.
- **Detoxification** – Medically supervised withdrawal from an addictive chemical substance, which may be done in a substance abuse facility.
- **Drug Testing** – *Precertified* drug testing is covered as an adjunct to substance abuse treatment.

The Plan also covers:

- **Enrollee Assistance Program** – Short-term counseling or other services that focus on problems of daily living, such as marital problems, conflicts at work, legal or financial difficulties, and dependent care needs.
- **www.liveandworkwell.com** – An interactive web site offering a large collection of wellness articles, service databases including a UBH Massachusetts *network provider* directory, tools, financial calculators and expert chats. To enter the site, log on to www.liveandworkwell.com and enter access code 10910.

These services are subject to certain Exclusions, which are found in Part III.

PART III – Benefits Explained

Mental Health and Substance Abuse Benefits

Network Services

In order to receive maximum network benefits for mental health, substance abuse and EAP treatment you must call United Behavioral Health toll free at 1-888-610-9039 (TDD: 1-800-842-9489) to *precertify* care and obtain a referral to a *network provider*.

Precertified network services are paid at 100% after the appropriate deductible and copayment (see schedule on page 74). The calendar year *out-of-pocket maximum* for network services is $1,000 per person.

The following do not count toward the *out-of-pocket maximum*:

- *Non-notification penalties*
- Cost of treatment subject to exclusions

If you fail to *precertify* your care, you may be charged a *non-notification penalty*. The *non-notification penalty* for each type of service is listed in the Benefit Highlights chart on pages 74-75, and in the following descriptions of services.

Network Benefits

Outpatient Care – The *copayment* schedule for network outpatient *covered services* is shown below:

Visits 1-4	No *copayment*
Visits 5 and over (individual)	$10 *copayment*
Visits 5 and over (group)	$5 *copayment*

Outpatient care *cross accumulates* with EAP services. (See pages 78-79 for a full explanation of EAP services.) You have four sessions with no *copayment* for either EAP, mental health, or substance abuse services.

Failure to *precertify* outpatient care results in a benefit reduction to the out-of-network benefit level of 80% coverage up to 15 visits per calendar year.

In-Home Care – In-home care is a *covered service* if *precertified*. Treatment that is *not pre-certified* but deemed to be a *covered service* receives out-of-network level reimbursement.

Intermediate Care – *Intermediate care* is covered if *precertified*. This includes, but is not limited to, 24-hour *intermediate care* facilities (for example, residential treatment, group homes, halfway houses, therapeutic foster care, day/partial hospital, and structured outpatient treatment programs). *Intermediate care* that is not pre-certified but deemed to be a *covered service* receives out-of-network level reimbursement.

Inpatient Care – Network inpatient care deemed to be a *covered service* in a general or psychiatric hospital, or substance abuse facility if *precertified* is covered at 100% after a $50 per calendar quarter deductible.

There is a $200 *non-notification penalty* for failure to *precertify* inpatient care.

Drug Testing – *Precertified* drug testing is covered as an adjunct to substance abuse treatment.

Substance Abuse Rehabilitation Incentive Program – Members who successfully complete all prescribed inpatient treatment and aftercare rehabilitation for substance abuse can apply for a refund for all inpatient and outpatient copays associated with their treatment.

Psychological Testing – Psychological testing, including neuropsychological testing, that is deemed to be a *covered service* is covered when *precertified*. Psychological testing that is not *precertified*, yet deemed to be a *covered service*, receives out-of-network level reimbursement if deemed to be a *covered service*.

Out-of-Network Services

Care from an *out-of-network provider* is paid at a lower level than network care. Out-of-network care is subject to *deductibles*, *copayments*, and *coinsurance*. In addition, out-of-network inpatient days and outpatient visits have certain restrictions that do not apply to network benefits.

Benefits are paid based on *allowed charges* that are UBH reasonable and customary fees or negotiated fee maximums. If your *out-of-network provider* or facility charges more than these *allowed charges*, you may be responsible for the difference, in addition to any amount not covered by the benefit.

Out-of-network mental health, and substance abuse treatment is subject to a $100 per person per calendar year *deductible*. Calendar year *deductibles* must be met prior to inpatient *deductibles* and *cross accumulate* between all out-of-network mental health and substance abuse benefit levels.

The *out-of-pocket maximum* for out-of-network care is $3,000 per person.

The following do not count toward the *out-of-pocket maximum*:

- Out-of-network calendar year *deductibles*
- Out-of-network inpatient *deductibles*
- *Non-notification penalties*
- Cost of treatment found not to be a *covered service*
- Cost of out-of-network outpatient services
- Charges in excess of UBH's *allowed charges*

All out-of-network care, except outpatient care, should be precertified with UBH. If you fail to *precertify*, your benefits may be subject to a *non-notification penalty*. If it is determined that care was not a *covered service*, no benefits will be paid.

Out-of-Network Benefits

Outpatient Care – Outpatient visits deemed to be a *covered service* are paid at 80% of UBH's *allowed charges*, up to a maximum of 15 visits per calendar year after your $100 annual *deductible* is met. Out-of-network care utilized to satisfy the annual *deductible* counts toward the 15 visit maximum. Charges paid by the covered person for outpatient out-of-network care do not count towards the out-of-pocket maximum. Outpatient out-of-network care does not need to be *precertified*.

In-Home Care – Included in outpatient care. Visits are covered at 80% for the first 15 visits per calendar year after appropriate annual *deductibles* have been met.

Intermediate Care – *Intermediate care* deemed to be a *covered service* is paid at 80% after appropriate annual *deductibles* have been met.

Inpatient Care – Out-of-network inpatient care deemed to be a *covered service* for mental health care is paid at 80% in a general hospital and at 80% for up to 60 days per calendar year in a psychiatric hospital. Inpatient care for substance abuse treatment deemed to be a *covered service* is paid at 80% for up to 30 days per calendar year in a general hospital or substance abuse facility. Charges for care that exceed the maximum number of days will not count toward the *out-of-pocket maximum.*

Each admission to a hospital or facility is subject to a $150 inpatient *deductible* per person in addition to the calendar year *deductible*. Failure to *precertify* inpatient care is subject to a *non-notification penalty* of $200 if the UBH case manager determines that the care is a *covered service*. No benefits will be paid if it was found not to be a *covered service*.

Drug Testing – There is no coverage for out-of-network drug testing.

See pages 79-81 for a list of Exclusions.

Enrollee Assistance Program

The Enrollee Assistance Program can help with the following types of problems:

- Breakup of a relationship
- Divorce or separation
- Becoming a step-parent
- Helping children adjust to new family members
- Death of a friend or family member
- Communication problems
- Conflicts in relationships at work
- Legal difficulties
- Financial difficulties
- Child or elder-care needs

- Aging
- Traumatic events

To use your EAP benefit, call 1-888-610-9039 toll free (TDD: 1-800-842-9489). The procedures for *precertifying* EAP care and referral to an EAP provider are the same as for mental health and substance abuse services. You will be referred by UBH clinician to a trained EAP provider and/or other specialized resource (e.g., attorneys, family mediators, dependent care services) in your community. The UBH clinician may recommend mental health and substance abuse services if the problem seems to require more extensive help than EAP services can provide.

LawPhone

LawPhone is a free legal referral service for Commonwealth enrollees. As a member of the Commonwealth Indemnity Plan, you have free access to LawPhone Legal Referral Service offered by UBH. This service provides:

- Free, unlimited telephone consultations with an attorney
- a free, 30-minute "face-to-face" consultation with an attorney
- a 25% discount for additional services provided by an attorney

For more information or to be connected with LawPhone, call UBH toll free at 1-888-610-9039 (TDD: 1-800-842-9489).

Network Benefits

EAP network benefits are paid according to the outpatient *copayment* schedule and *cross accumulate* with those benefits. No *copayment* is required for the first four visits, provided they have not been used for mental health and substance abuse care. If you use your first four visits as EAP sessions, all additional sessions for mental health and substance abuse services will be subject to the *copayment* schedule for outpatient treatment set forth on page 77.

Out-of-Network Benefits

There is no coverage for out-of-network EAP services.

What's Not Covered – Exclusions

The following exclusions apply regardless of whether the services, supplies, or treatment described in this section are recommended or prescribed by the Covered Person's provider and/or are the only available treatment options for the Covered Person's condition.

This Plan does not cover services, supplies or treatment relating to, arising out of, or given in connection with the following:

- Services performed in connection with conditions not classified in the current edition of the Diagnostic and Statistical Manual of Mental Health Disorders (DSM).
- Prescription drugs or over the counter drugs and treatments. (Refer to your prescription drug plan to determine whether prescription drugs are a covered benefit.)
- Services or supplies for MHSA treatment that, in the reasonable judgment of UBH, are any of the following:
  - not consistent with the symptoms and signs of diagnosis and treatment of the behavioral disorder, psychological injury or substance abuse;
  - not consistent with prevailing national standards of clinical practice for the treatment of such conditions;

– not consistent with prevailing professional research demonstrating that the service or supplies will have a measurable and beneficial health outcome;

– typically do not result in outcomes demonstrably better than other available treatment alternatives that are less intensive or more cost effective; or

– not consistent with UBH's Level of Care Guidelines or best practices as modified from time to time.

UBH may consult with professional clinical consultants, peer review committees or other appropriate sources for recommendations and information.

- Unproven, investigational or experimental services – services, supplies, or treatments that are considered unproven, investigational, or experimental because they do not meet generally accepted standards of medical practice in the United States. The fact that a service, treatment, or device is the only available treatment for a particular condition will not result in it being a *Covered Service* if the service, treatment, or device is considered to be unproven, investigational, or experimental.
- Custodial Care except for the acute stabilization of the Covered Person and returning the Covered Person back to his or her baseline levels of individual functioning. Care is determined to be custodial when:
  – it provides a protected, controlled environment for the primary purpose of protective detention and/or providing services necessary to assure the Covered Person's competent functioning in activities of daily living; or
  – it is not expected that the care provided or psychiatric treatment alone will reduce the disorder, injury or impairment to the extent necessary for the Covered Person to function outside a structured environment. This applies to Covered Persons for whom there is little expectation of improvement in spite of any and all treatment attempts.
- Covered Persons whose repeated and volitional non-compliance with treatment recommendations result in a situation in which there can be no reasonable expectation of a successful outcome.
- Neuropsychological testing for the diagnosis of attention deficit disorder.
- Examinations or treatment, unless it otherwise qualifies as Behavioral Health Services, when:
  – required solely for purposes of career, education, sports or camp, travel, employment, insurance, marriage or adoption;
  – ordered by a court except as required by law;
  – conducted for purposes of medical research; or
  – required to obtain or maintain a license of any type.
- Herbal medicine, holistic or homeopathic care, including herbal drugs, or other forms of alternative treatment as defined by the Office of Alternative Medicine of the National Institutes of Health.
- Nutritional counseling, except as prescribed for the treatment of primary eating disorders as part of a comprehensive multimodal treatment plan.
- Weight reduction or control programs (unless there is a diagnosis of morbid obesity and the program is under medical supervision), special foods, food supplements, liquid diets, diet plans or any related products or supplies.

- Services or treatment rendered by unlicensed providers, including pastoral counselors (except as required by law), or which are outside the scope of the providers' licensure.
- Personal convenience or comfort items including, but not limited to, such items as TVs, telephones, computers, beauty/barber service, exercise equipment, air purifiers or air conditioners.
- Light boxes and other equipment, including durable medical equipment, whether associated with a behavioral or non-behavioral condition.
- Private duty nursing services while confined in a facility.
- Surgical procedures including but not limited to sex transformation operations.
- Smoking cessation related services and supplies.
- Travel or transportation expenses unless UBH has requested and arranged for the Covered Person to be transferred by ambulance from one facility to another.
- Services performed by a provider who is a family member by birth or marriage, including spouse, brother, sister, parent or child. This includes any service the provider may perform on himself or herself.
- Services performed by a provider with the same legal residence as the Covered Person.
- Behavioral Health Services for which the Covered Person has no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under the Plan.
- Charges in excess of any specified Plan limitations.
- Any charges for missed appointments.
- Any charges for record processing except as required by law.
- Services provided under another plan – services or treatment for which other coverage is required by federal, state or local law to be purchased or provided through other arrangements. This includes, but is not limited to, coverage required by workers' compensation, no-fault auto insurance, or similar legislation. If coverage under workers' compensation or a similar law is optional for the Covered Person because the Covered Person could elect it or could have it elected for him or her, benefits will not be paid if coverage would have been available under the workers' compensation or similar law had that coverage been elected.
- Behavioral Health Services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country when the Covered Person is legally entitled to other coverage.
- Treatment or services received prior to the Covered Person being eligible for coverage under the Plan or after the date the Covered Person's coverage under the Plan ends.

Words in italics are defined in Part II

Commonwealth Indemnity Plan
Administered by UNICARE

Appendices

Appendix A: Member Confidentiality Statement

Appendix B: Claim Form

MEMBER CONFIDENTIALITY STATEMENT

UniCare Life & Health Insurance Company
Commonwealth Indemnity Medicare Extension Plan

UniCare, the administrator for the Commonwealth Indemnity Medicare Extension Plan, protects the confidentiality of its members' personal, financial and health information as required by law, accreditation standards and its internal policies and procedures. This Member Confidentiality Statement explains your rights, our legal duties and our privacy practices.

Your Financial Information

In order to conduct health insurance activities, we collect and use several different types of financial information. This includes information that you provide directly to us on applications or other forms, such as your name, address, age, and information about dependents. We accumulate information about your transactions with our affiliates, others, or us such as policy coverage, premiums, and payment history. We also retain any information we may receive from a consumer-reporting agency such as your credit history.

We use physical, electronic, and procedural safeguards to protect your confidential information. We make it available only to our employees, affiliates or others who need it to service or maintain your policy, to conduct insurance transactions and functions, or for other legally permitted or required purposes.

Your Health Information

THIS INFORMATION DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We collect, use and disclose information provided by and about you for health care payment and operations, or when we are otherwise permitted or required by law to do so.

For Payment: We may use and disclose information about you in managing your account or benefits, and paying claims for medical care you receive through your plan. For example, we maintain information about your premium and deductible payments. We may also provide information to a doctor's office to confirm your eligibility for benefits, or we may ask a hospital for details about your treatment so that we may review and pay the claim for your care.

For Health Care Operations: We may use and disclose medical information about you for our operations. For example, we may use information about you to review the quality of care and services you receive; to provide you case management or care coordination services, such as for asthma, diabetes, or traumatic injury; or to seek accreditation.

We may contact you to provide information about treatment alternatives or other health-related benefits and services. For example, when you or your dependents reach a certain age, we may notify you about additional products or programs for which you may become eligible, such as Medicare supplements or individual coverage. We may also notify you about routine medical check-ups and tests. We may, in the case of some group health plans, share limited health information with your employer or other organizations that help pay for your membership in the plan, in order to enroll you, or to permit the plan sponsor to perform plan administrative

functions. Plan sponsors that receive this information are required by law to have safeguards in place to protect it from inappropriate uses.

As Permitted or Required by Law:
Information about you may be used or disclosed to regulatory agencies, such as during audits, licensure or other proceedings; for administrative or judicial proceedings; to public health authorities; or to law enforcement officials, such as to comply with a court order or subpoena.

Authorization: Other uses and disclosures of protected health information will be made only with your written permission, unless otherwise permitted or required by law. You may revoke this authorization, at any time, in writing. We will then stop using your information for that purpose. However, if we have already used your information based on your authorization, you cannot take back your agreement for those past situations.

Your Rights

Under regulations effective April 2003, you have the following rights over your health information. Under these rules, you have the right to:

- Send us a written request to see or get a copy of information that we have about you, or amend your personal information that you believe is incomplete or inaccurate. If we did not create the information, we will refer you to the source, such as your physician or hospital.

- Request additional restrictions on uses and disclosures of your health information. We are not required to agree to these requests.

- Request that we communicate with you about medical matters using reasonable alternative means or at an alternative address, if communications to your home address could endanger you.

- Receive an accounting of our disclosures of your medical information, except when those disclosures are made for treatment, payment or health care operations, or the law otherwise restricts the accounting. We are not required to give you a list of disclosures made before April 14, 2003.

Complaints

If you believe your privacy rights have been violated, you have the right to file a complaint with us, or with the federal government. You will not be penalized for filing a complaint.

Copies and Changes

You have the right to receive an additional copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy.

We reserve the right to revise this notice. A revised notice will be effective for information we already have about you as well as any information we may receive in the future. We are required by law to comply with whatever privacy notice is currently in effect. We will communicate any changes to our notice through subscriber newsletters, direct mail, and/or our web site.

Contact Information

If you want to exercise your rights under this notice or if you wish to communicate with us about privacy issues or to file a complaint with us, please contact the Commonwealth Service Center at 1-800-442-9300.

UNICARE.

UNICARE LIFE & HEALTH INSURANCE COMPANY
ANDOVER SERVICE CENTER
CLAIMS DEPARTMENT
P.O. BOX 8019
ANDOVER, MA 01810-8019
1-800-442-2500

CONTROL 26585 / 08136 *

Medicare Beneficiary
After Medicare pays its portion of a claim for medical charges, please complete Section 1, attach the explanation of Medicare payment and/or any bill that indicates the total provider charge, the Medicare allowed charge as well as the Medicare payment, and send to UniCare.

Non-Medicare Enrollee:
Please complete Sections 1, 2, and 3 in order to receive prompt reimbursement. Section 4 can be completed by your physician or an itemized bill can be submitted in place of Section 4.

SECTION 1 — If you are a Medicare Beneficiary, please complete this section

Your Date of Birth	Male ☐ Female ☐	Marital Status (Check one) ☐ Single ☐ Divorced ☐ Married ☐ Legally Separated
Name of Spouse	Spouse's Date of Birth	Name and Address of Spouse's Employer

Is Claim For Your Spouse/Dependent? ☐ No ☐ Yes	Name of Dependent, If Other Than Spouse	Relationship To You ☐ Child ☐ Stepchild ☐ Other ☐ Spouse	Dependent's Date of Birth	Is Your Dependent Married? ☐ No ☐ Yes Full-Time Student ? ☐ No ☐ Yes Employed Full-Time ? ☐ No ☐ Yes

Date of First Treatment For This Illness or Injury	Name and Address of Doctor (Please Print)

Is This Condition Due to an Injury? ☐ No ☐ Yes	Is This Condition Due to an Occupational Injury or Disease ? ☐ No ☐ Yes	Date of Injury	Where Did It Occur ?

Describe How Accident Happened

Are You, Your Spouse or Your Dependent Children In Any Other Health Benefit Plan Including Medicare? ☐ No ☐ Yes	If Yes, Name of Member/Subscriber (If different from Patient)	Relationship to Patient	Other Group/Policy/Contract No.
Member/Subscriber Soc. Sec. No.	Name and Address of Other Plan Claim Payment Office		

In consideration of benefit payment under this Group Policy, without reduction for any right of recovery under the Worker's Compensation Act, I assign to the UniCare Life & Health Insurance Company my right, title, and interest to any recovery of Workers' Compensation benefits for this disease or injury, however recovered, to the extent of benefits paid under this Group Policy.

I authorize any physician or other medical professional, hospital or other medical care institution, insurer, medical or hospital service or prepaid health plan, employer or group policyholder, contractholder or benefit plan administrator to disclose to UniCare Life & Health Insurance Company or any plan administrator, consumer reporting agency, or attorney acting on UniCare Life & Health Insurance Company's behalf, any medical information and any employment related information regarding the patient. This information will be used only to evaluate and administer claims for benefits.

This authorization is valid for the duration of the claim.

I know I have a right to receive a copy of this authorization and that a photographic copy is as valid as the original.

Any person who knowingly files a statement of claim containing false, incomplete or misleading information with intent to injure, defraud, or deceive any insurance company is guilty of a crime.

Employee's/Retiree's Signature

Patient Signature, if patient is not employee (Parent, if patient is a minor)

Date

*UniCare does not insure benefits under control number 08136. Your employer is solely responsible for determination of entitlement to, and payment of, any amounts due under the plan.

FORM 156593 ED. 4/97

SECTION A — PATIENT INFORMATION

Patient's Name (Last / First / MI)	Patient's Sex	Patient's Relationship to Employee/Patient
	☐ Male ☐ Female	☐ Self ☐ Child ☐ Spouse ☐ Other
Patient's Street Address	**Patient's Date of Birth**	**Was Condition Related To** Patient's Employment ☐ Yes ☐ No; An Auto Accident ☐ Yes ☐ No
Other Health Insurance Coverage – Enter Name of Policyholder and Plan Name and Address and Policy or Medical Assistance Number (Including Medicaid, Medicare)	**Insured's I.D. No. (S.S. No.)**	**Insured's Group No. (Or Group Name)**
Patient's or Authorized Person's Signature I Authorize the Release of any Medical Information Necessary to Process this Claim. X	**Insured's Name**	
The GEICO indemnity Plan will pay benefits directly to the provider unless a receipted bill is attached.	**Insured's Address**	

SECTION B — PHYSICIAN OR SUPPLIER INFORMATION

Date of Illness (First Symptom) or Injury (Accident) or Pregnancy (LMP)	Date First Consulted You For This Condition	Patient ever had same or similar symptoms ? ☐ Yes ☐ No	Dates of Total Disability From / Through	Dates of Partial Disability From / Through

Name of Referring Physician	For Services Related to Hospitalization Give Hospitalization Dates: ADMITTED / DISCHARGED

Name & Address of Facility Where Services Rendered (If other than home or office)	Were Laboratory Work Performed Outside Your Office ? ☐ Yes ☐ No CHARGES	Date Patient Able to Return to Work

Diagnosis or Nature of Illness or Injury, RELATE ICDS TO PROCEDURE IN COLUMN D BY REFERENCE TO NUMBERS 1, 2, 3, ETC. OR DX CODE

1.
2.
3.
4.

Date of Service	Place of Service-*	Fully Describe Procedures, Medical Services or Supplies Furnished for Each Date Given. Procedure Code CPT4 (Explain Unusual Services or Circumstances)	D Diagnosis Code ICDS	Charges	

Signature of Physician or Supplier	Questions 7, 8 & 9 Must Be Answered Under Authority of Law.	Total Charge	Amount Paid	Balance Due
Signed / Date	7. Your Soc. Sec. No.	8. Physician's or Supplier's Name, Address, Zip Code & Telephone No.		
Your Patient's Account No.	**9. Your Employer I.D. No.**	I.D. No.		

*PLACE OF SERVICE CODES

1– (H) –INPATIENT HOSPITAL
2– (OH) –OUTPATIENT HOSPITAL
3– (O) –DOCTOR'S OFFICE
4– (H) –PATIENT'S HOME
5– DAY CARE FACILITY (PSY)
6– NIGHT CARE FACILITY (PSY)
7– (NH) –NURSING HOME
8– (SNF) –SKILLED NURSING FACILITY
9– AMBULANCE
0– (OL) –OTHER LOCATION
A– (IL) –INDEPENDENT LABORATORY
B– –OTHER MEDICAL/SURGICAL FACILITY

APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8-74

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Commonwealth Service Center
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Andover MA 01810-0916
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www.unicare-cip.com

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